BOSTON MEDICAL CENTER HealthNet Plan

ENVISION RX OPTIONS

PRIOR AUTHORIZATION REQUEST FORM

BMCHP Angiotensin Receptor Antag. - Policy 9.131
Candesartan/Candesartan HCT, Diovan/Valsartan HCT, Edarbi/Edarbyclor, Amlodipine-telmisartan, Azor, Benicar/Benicar HCT, Eprosartan 600mg, Exforge/Exforge HCT, Telmisartan/Telmisartan HCT, Teveten 400mg/Teveten HCT, Tribenzor

Phone: 888-566-0008 **Fax back to: 866-414-3453**

ENVISION RX OPTIONS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is the request for initial or continuing therapy? If continuing therapy, include the treatment start date.

☐ Initial
☐ Continuing / Start date (mm/yy):

Q2. Which medication is coverage being requested for?

☐ Azor
☐ Benicar/Benicar HCT
☐ Candesartan/Candesartan HCT
☐ Diovan
☐ Valsartan HCT
☐ Edarbi/Edarbyclor
☐ Exforge/Exforge HCT
☐ Telmisartan/Telmisartan HCT
☐ Teveten 400mg/Teveten HCT
☐ Eprosartan 600mg
☐ Tribenzor
☐ Amlodipine-telmisartan

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Patient Name: **Prescriber Name:**

Q3. Please provide the patient's diagnosis:

Q4. Please indicate which medications have been tried in the past and the patient received an inadequate response or intolerance to therapy. Please describe the inadequate response or intolerance to treatment, below:

- ☐ Candesartan
- ☐ Candesartan HCT
- ☐ Diovan
- ☐ Valsartan HCT
- ☐ Edarbi
- ☐ Edarbyclor
- ☐ Irbesartan
- ☐ Irbesartan HCT
- ☐ Losartan
- ☐ Losartan HCT

Q5. Is the patient pregnant?

☐ Yes ☐ No

Prescriber Signature

Date

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