Please note: All information below is required to process this request
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
OptumRx • M/S CA 106-0286 • 3515 Harbor Blvd. • Costa Mesa, CA 92626

Entresto® (UnitedHealthcare Medicare plans only) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		
Is the physician supplying the medication? ❑ **Yes** ❑ **No**		

Clinical Information (required)

Select the diagnosis below:
❑ Heart failure (with or without hypertension)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:
Does the patient have an ejection fraction ≤ 40%? ❑ **Yes** ❑ **No**
Is the patient's heart failure classified as one of the following: New York Heart Association Class II, III or IV? ❑ **Yes** ❑ **No**
Was the medication prescribed by or in consultation with a cardiologist? ❑ **Yes** ❑ **No**
Does the patient have a history of angioedema associated with the use of Angiotensin converting enzyme (ACE) inhibitor therapy? ❑ **Yes** ❑ **No**
Does the patient have a history of angioedema associated with the use of Angiotensin receptor blocker (ARB) therapy? ❑ **Yes** ❑ **No**
Will the patient discontinue use of any concomitant ACE inhibitor or ARB before initiating treatment with Entresto? ❑ **Yes** ❑ **No**
Please note: ACE inhibitors must be discontinued at least 36 hours prior to initiation of Entresto
Is the patient receiving concomitant aliskiren (Tekturna) therapy? ❑ **Yes** ❑ **No**
Is the patient pregnant? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following question:
Is there documentation of positive clinical response to therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.