Prior Authorization Form

ANGIOTENSIN II RECEPTOR ANTAGONIST/ DIURETIC COMBINATIONS (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at **1-888-836-0730**. Please contact CVS Caremark at **1-855-240-0536** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Atacand HCT (candesartan/ hydrochlorothiazide).

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (specify drug): Atacand HCT (candesartan/ hydrochlorothiazide)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1. Preferred products are available at a lower cost. Can your patient be switched to a preferred drug/ product? **Y** ☐ **N** ☐
   Available Formulary Alternatives: *candesartan- hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan- hydrochlorothiazide, telmisartan- hydrochlorothiazide, valsartan- hydrochlorothiazide,* BENICAR HCT

   [If yes, provide your patient with a new prescription for the preferred product.]
2. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? **Y** ☐ **N** ☐
3. Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature? **Y** ☐ **N** ☐
4. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below: Drug Name, Trial Year, Reason for Failure **Y** ☐ **N** ☐

   _____

   Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternatives. Required Formulary Alternatives 3 in a class with 3 or more alternatives: *candesartan- hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan- hydrochlorothiazide, telmisartan- hydrochlorothiazide, valsartan- hydrochlorothiazide,* BENICAR HCT

   [If yes, no further questions]

5. Does the patient have a contraindication to all the alternatives? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a claim ultimately paid by the United States government or any state government may be subject to civil penalties and treble damages under both the federal and state False Claims Acts. See, e.g., 31 U.S.C. §§ 3729-3733.

Prescriber (Or Authorized) Signature and Date