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 Teveten HCT (eprosartan/ hydrochlorothiazide).

Patient Information									
Patie	ent Name:								
Patient Phone:									
Patient ID:									
Patie No:	ent Group								
Patient DOB:									
Prescribing Physician									
Physician Name:									
Physician Phone:									
Physician Fax:									
Physician Address:									
City,	State, Zip:			П					
Drug	Name (specify drug): Teveten HCT (eprosartan/ hydrochlorothiazide)								
Quantity: Frequency: Strength:									
Route of Administration: Expected Length of Therapy:									
Diag	nosis: ICD Code:								
Comments:									
Pleas 1.	se check the appropriate answer for each applicable question. Preferred products are available at a lower cost. Can your patient be switched to a preferred drug/ product? Available Formulary Alternatives: candesartan- hydrochlorothiazide, irbesartan-hydrochlorothiazide, losartan- hydrochlorothiazide, telmisartan- hydrochlorothiazide, valsartan- hydrochlorothiazide, BENICAR HCT	Y		N					
2.	[If yes, provide your patient with a new prescription for the preferred product.] 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?	Υ		N	
and plan be n gove	est that the medication requested is medically necessary for this patient. I further attest that the true, and that documentation supporting this information is available for review if requested be sponsor, or, if applicable, a state or federal regulatory agency. I understand that any person nade a false record or statement that is material to a claim ultimately paid by the United State ernment may be subject to civil penalties and treble damages under both the federal and state C. §§ 3729-3733.	y the c who kn s gove	laims pr lowingly rnment	ocess make or any	or, the health es or causes to state

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug Pas immediately and securely online – without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.