# US Family Health Plan
# Prior Authorization Request Form for
# **Sacubitril/valsartan (Entresto)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

**Step 1** **Please complete patient and physician information** (please print):

| | | | |
|---|---|---|---|
| Patient Name: | | Physician Name: | |
| Address: | | Address: | |
| | | | |
| Sponsor ID # | | Phone #: | |
| Date of Birth: | | Secure Fax #: | |

**Step 2** **Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Is the initial prescription written by or in consultation with a cardiologist?** | ☐ Yes<br>Proceed to question 2 | ☐ No<br>Coverage not approved |
| **2. Is the patient greater than or equal to 18 years of age?** | ☐ Yes<br>Proceed to question 3 | ☐ No<br>Coverage not approved |
| **3. Does the patient have a documented diagnosis of chronic heart failure (New York Heart Association class II-IV) with a left ventricular ejection fraction less than or equal to 35% with continued heart failure symptoms?** | ☐ Yes<br>Proceed to question 4 | ☐ No<br>Coverage not approved |
| **4. Will the Member be concomitantly taking an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin receptor blocker (ARB)?** | ☐ Yes<br>Coverage not approved | ☐ No<br>Proceed to question 5 |
| **5. Does the patient have a history of angioedema due to an ACE inhibitor or ARB?** | ☐ Yes<br>Coverage not approved | ☐ No<br>Coverage approved |

**Step 3** **I certify the above is true to the best of my knowledge.**
Please sign and date:

Prescriber Signature _____ Date _____