US Family Health Plan
Prior Authorization Request Form for
Renin Angiotensin Antihypertensive Agents **(RAA agents)**

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 **617-562-5296**

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 note:**

The PREFERRED renin angiotensin antihypertensive (RAA) agents are: Cozaar (losartan), Hyzaar (losartan-HCTZ), Diovan (valsartan), Diovan HCT (valsartan-HCTZ), Exforge (valsartan-amlodipine), Exforge HCT (valsartan-amlodipine-HCTZ), Micardis (telmisartan), Micardis HCT (telmisartan-HCTZ), Avapro (irbesartan) Avalide (irbesartan + HCTZ) and Twynsta (telmisartan-amlodipine). **They are covered without prior authorization. You do NOT need to complete this form for coverage of the preferred RAA agents.**

For Prestalia *ONLY*: in addition to the agents above, generic ACE inhibitors are also preferred agents (for example, benazepril, captopril, enalapril, fosinopril, lisinopril, moexipril, perindopril, quinapril, ramipril, trandolapril)**.**

Step 3 **Requested agent:**

Step 4 **Please complete the clinical assessment:**

1. Has the patient had a trial of one preferred renin angiotensin antihypertensive (RAA) agent and was unable to tolerate treatment due to adverse effects?	☐ Yes Sign and date below	☐ No Proceed to question 2
2. Has the patient had a trial of one preferred RAA agent and has had an inadequate response?	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Does the patient have a contraindication to the preferred RAA agents that is not expected to occur with the requested agent?	☐ Yes Sign and date below	☐ No Coverage not approved

Step 5 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[14 February 2018]