



**Prior Authorization Request Form – Angiotensin II Receptor Blockers (ARBs)**

**Instructions:**

This form is to be used by participating providers to request coverage for Angiotensin II Receptor Blocker (ARB) medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services      Phone: 1-800-918-7550  
 P. O. Box 2586, Worcester, MA 01606                                      Fax: 1-800-918-7542

An Angiotensin II Receptor Blockers (ARBs) step therapy program has been developed to encourage the use of first-line therapies before second or third-line therapies are used for the same indication.		
<b>First-line therapies:</b> benazepril, benazepril/HCTZ moexipril, moexipril/HCTZ captopril, captopril/HCTZ quinapril, quinapril/HCTZ enalapril, enalapril/HCTZ lisinopril, lisinopril/HCTZ fosinopril, fosinopril/HCTZ ramipril capsules, trandolapril	<b>Second-line therapies:</b> Avapro, Avalide losartan, losartan-HCTZ Diovan, Diovan HCT	<b>Third-line therapies:</b> Atacand, Atacand HCT Benicar, Benicar HCT Micardis, Micardis HCT Teveten, Teveten HCT Edarbi

**PRINT and complete ALL of the following boxes:**

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
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4. Prescriber's FULL Name & Specialty:	5. Contact Person at Office:
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6. Prescriber's FAX & Telephone Number:    Fax: (    )                                      Tel: (    ) Mailing Address:
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7. Requested Drug:	8. Dose, Frequency and Duration of Requested Drug:
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9. Has the member been started and stabilized on the requested drug within the last 90 days? <input type="checkbox"/> Yes <input type="checkbox"/> No - If 'yes', duration of therapy = _____
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10. Does the member have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, please specify: _____
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11. Has the member previously tried the following?			
Drug Name (please check all that apply)	Response (please check all that apply)		
<input type="checkbox"/> benazepril or benazepril/HCTZ	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> captopril or captopril/HCTZ	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> enalapril or enalapril/HCTZ	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> fosinopril or fosinopril/HCTZ	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> lisinopril or lisinopril/HCTZ	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> moexipril or moexipril/HCTZ	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> quinapril or quinapril/HCTZ	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> trandolapril	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> Aceon (perindopril)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> ramipril	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy

12. Has the member previously tried all of the following drugs?			
Drug Name (please check all that apply)	Response (please check all that apply)		
<input type="checkbox"/> Avapro or Avalide	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> losartan or losartan/HCTZ	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> Diovan or Diovan HCT	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy

**Signature:**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature

Date