Iowa Department of Human Services

Request for Prior Authorization
ANGIOTENSIN RECEPTOR BLOCKER BEFORE ACE INHIBITOR

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Payment for Angiotensin Receptor Blockers (ARB) and Angiotensin Receptor Blocker Combinations will only be considered for cases in which there is a contraindication or therapy failure with at least one ACE-I or ACE-I Combination. A completed prior authorization form will need to be submitted if a trial with an ACE-I or ACE-I Combination of at least 30 days in length is not found in the point-of-sale system and/or unless evidence is provided that use of an ACE-I or ACE-I Combination would be medically contraindicated. Prior authorization is required for all non-preferred ARBs and ARB Combinations the first day of therapy. Payment for a non-preferred ARB or ARB Combination will be considered following documentation of recent trials and therapy failures with a preferred ACE-I or ACE-I Combination AND a preferred ARB or ARB Combination.

Preferred

- ☐ Amlodipine/Olmesartan
- ☐ Amlodipine/Valsartan
- ☐ Amlodipine/ Valsartan/HCTZ
- ☐ Irbesartan
- ☐ Irbesartan HCT
- ☐ Losartan
- ☐ Losartan HCT
- ☐ Valsartan
- ☐ Valsartan HCT

Non-Preferred

- ☐ Atacand
- ☐ Atacand HCT
- ☐ Avalide
- ☐ Avapro
- ☐ Azor
- ☐ Benicar
- ☐ Benicar HCT
- ☐ Cozaar
- ☐ Diovan
- ☐ Diovan HCT
- ☐ Edarbi
- ☐ Edarbyclor
- ☐ Eprosartan
- ☐ Exforge
- ☐ Exforge HCT
- ☐ Hyzaar
- ☐ Micardis
- ☐ Micardis HCT
- ☐ Olmesartan
- ☐ Olmesartan/Amlodipine/HCTZ
- ☐ Olmesartan/HCTZ
- ☐ Telmisartan
- ☐ Telmisartan/Amlodipine
- ☐ Telmisartan HCT
- ☐ Teveten
- ☐ Teveten HCT
- ☐ Tribenzor
- ☐ Twynsta
- ☐ Valturna

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis:_____

Preferred ACE Inhibitor Trial: Drug Name_____ Strength_____

Dosage Instructions_____ Trial date from: _____ Trial date to:_____

Failure reason with ACE Inhibitor: _____

Medical or contraindication reason to override ACE Inhibitor trial requirements: _____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other relevant information:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*