



Please Note: Medical Necessity Prior Authorization may be overridden for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**
Azor® (amlodipine/ olmesartan medoxomil)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Background watermark: 'SAMPLE' repeated diagonally across the page.

Name _____
Address _____

Rx
Rx: amlodipine
10mg
quantity # _____
sig: 1 in AM
as directed by physician

MD _____
Signature _____

Name _____
Address _____

Rx valsartan 80mg;
quantity # _____
sig: 1 orally daily
[valsartan 80mg
substitute for olmesartan 40mg]
as directed by physician

Dx HYPERTENSION
ICD10: D 50.9
MD _____
Signature _____

SAMPLE



Prescriber Information

| | |
|--|--|
| Last Name: <input type="text"/> DEA/NPI: <input type="text"/> Phone <input type="text"/> | First Name <input type="text"/> Specialty: <input type="text"/> Fax <input type="text"/> |
|--|--|

Member Information

| | |
|--|--|
| Last Name: <input type="text"/> Member ID Number <input type="text"/> | First Name <input type="text"/> DOB: <input type="text"/> |
|--|--|

Medication Information:

| | |
|--|--|
| Drug Name and Strength: <hr/> Diagnosis: <hr/> | Quantity and Dosing: <hr/> Duration: <hr/> |
|--|--|

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Azor, Tribenzor Prior Authorization Form

You must answer ALL of the following questions

| | | |
|---|---|---|
| 1. Has the patient had a trial and failure of one of the following therapies? <i>Please provide documentation.</i> <ul style="list-style-type: none"> • Generic ACE inhibitor • Generic ACE inhibitor combo • Generic losartan • Generic losartan/HCTZ | Y | N |
| 2. Does the patient have a prior history of receiving concurrent therapy with Benicar (olmesartan) together with amlodipine? <i>Please provide documentation.</i> | Y | N |
| 3. Does the patient have documented dysphagia supported by chart notes from the concurrent treatment with two component drugs (e.g., olmesartan/amlodipine)? <i>Please include chart notes.</i> | Y | N |



Exforge (amlodipine/valsartan), Exforge HCT (amlodipine/valsartan/hydrochlorothiazide) Prior Authorization Form

You must answer ALL of the following questions

| | | |
|---|---|---|
| 1. Has the patient had a trial and failure of one of the following therapies? <i>Please provide documentation.</i> | Y | N |
| <ul style="list-style-type: none"> • Generic ACE inhibitor • Generic ACE inhibitor combo • Generic losartan • Generic losartan/HCTZ | | |
| 2. Does the patient have a prior history of receiving concurrent therapy with Diovan (valsartan) together with amlodipine? <i>Please provide documentation.</i> | Y | N |
| 3. Does the patient have documented dysphagia? <i>Please provide documentation.</i> | Y | N |

Twynsta (telmisartan/amlodipine) Prior Authorization Form

You must answer ALL of the following questions

| | | |
|---|---|---|
| 1. Has the patient had a trial and failure of one of the following therapies? <i>Please provide documentation.</i> | Y | N |
| <ul style="list-style-type: none"> • Generic ACE inhibitor • Generic ACE inhibitor combo • Generic losartan • Generic losartan/HCTZ | | |
| 2. Does the patient have a prior history of receiving concurrent therapy with Micardis (telmisartan) together with amlodipine? <i>Please provide documentation.</i> | Y | N |
| 3. Does the patient have documented dysphagia? <i>Please provide documentation.</i> | Y | N |

Please note, not all drugs/diagnoses are covered on all plans.

Comments: _____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

Prescriber or Authorized Signature

Date

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).



Contact Information:

Telephone: (855)251.9116

Fax: (248)593.9575

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**PRIOR AUTHORIZATION FORM:
COVER PAGE**

| MEMBER INFORMATION | | | |
|---|---|---------------------|--------------|
| First Name | | Last Name | |
| Plan | | | |
| Member ID | | Date of Birth | |
| DRUG INFORMATION | | | |
| Drug Name | | | |
| Quantity | | ICD-10 | |
| Directions | | Duration of Therapy | |
| Diagnosis | | | |
| PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW. | | | |
| Medication/Failure Reason: | | | |
| | | | |
| | | | |
| | | | |
| IgE: _____ | | | |
| ESR: _____ CRP: _____ # Joints: _____ %BSA: _____ | | | |
| Height: _____ Weight: _____ BMI: _____ | | | |
| HA1C: _____ Hemoglobin: _____ Hematocrit: _____ T-Score: _____ | | | |
| Dialysis: _____ Long Term Care Facility: _____ Self Injecting: _____ | | | |
| Stimulation test: _____ / _____ Growth velocity: _____ #Chemotherapy cycles/month: _____ | | | |
| Mini-Mental Status Test: _____ Baseline Free testosterone/Total testosterone: _____ / _____ | | | |
| HCV RNA viral load: _____ Viral Genotype: _____ ALT: _____ | | | |
| PHYSICIAN INFORMATION | | | |
| Physician Signature | | Date | |
| Physician Name | | NPI # | |
| Phone Number | | Fax Number | |
| Action Needed | Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function | | Pharmacy Fax |
| | <input type="checkbox"/> Urgent <input type="checkbox"/> For Review | | |
| The information contained in this facsimile message, including the attachments, may be privileged, may constitute inside information and is intended only for use of the addressee. If the reader of this message is not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited and may be unlawful. If you have received this communication in error, please immediately notify me by replying to this message and destroy the original message. | | | |