



**Independence
Blue Cross**

**Prior Authorization Form
Oral antihypertensive agents**

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug requested: Diovan® Diovan HCT®, Benicar® Benicar HCT®, Cozaar® Hyzaar®, Azor Exforge Exforge HCT
 Tekturna HCT Avapro® Avalide®, Teveten® Teveten HCT® Micardis® Micardis HCT®, Atacand® Atacand HCT®
 Tekturna Twynsta® Valturna®

Date: _____ Patient ID#: _____ DOB: _____
Patient Name: _____ Provider NPI: _____
Prescribing Physician: _____ Office Contact: _____
Office Fax #: _____ Office Phone: _____

1. DIAGNOSIS FOR DRUG REQUESTED:

Hypertension Type II Diabetes with renal insufficiency Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. PATIENT HISTORY:

- a. Has the patient tried and failed an ACE containing product for a minimum of 30 days? Yes No
- b. Has the patient tried and failed an ACE containing product in the past 6 months? Yes No
- c. Does the patient have an intolerance or contraindication to an ACE containing product? Yes No

Please specify _____

FOR THE FOLLOWING QUESTIONS (D, E, F, G) DOCUMENT THE DATES IN THE MEDICATION HISTORY SECTION

- d. Has the patient tried and failed Diovan containing product for a minimum of 30 days? Yes No N/A
- e. Has the patient tried and failed Benicar containing product for a minimum of 30 days? Yes No N/A
- f. Has the patient tried amlodipine containing product for a minimum of 30 days? Yes No N/A
- g. Is the patient non-compliant with at least a 30 day trial of concurrent therapy of Diovan/Diovan HCT and an amlodipine containing product? Yes No N/A

Tekturna/Tekturna HCT, Valturna & Azor Only:

- h. Has the patient tried and failed or has a contraindication/intolerance/allergy to an ACE containing product? Yes No N/A
- i. Has the patient tried and failed or has a contraindication to Diovan containing product? Yes No N/A
- j. Has the patient tried and failed or has a contraindication to Benicar containing product? Yes No N/A
- k. Has the patient tried and failed or has a contraindication to amlodipine containing product? Yes No N/A
- l. Has the patient tried and failed or has a contraindication to beta blocker, thiazide diuretic or a calcium channel blocker? Yes No N/A

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

