



**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?  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

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**