Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Angiotensin Receptor Blockers

Atacand HCT®, Avalide®, Benicar HCT®, Hyzaar®, Diovan HCT™, Micardis HCT®, and Tevetan HCT®

BCBSVT and TVHP Fax # (888)–255-1006

If approval criteria are met BCBSVT/TVHP will authorize coverage of an Angiotensin Receptor Blocker.
Thank you for your assistance.
PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _______________ Patient Name: ___________________________

Member ID#:____________________ Date of Birth: ____________________________

Provider Name:__________________ Provider Phone: __________________________

Provider Fax: _____________________ PCP Name: _____________________________

Indicate which agent is being requested:	
Atacard HCT®	☐
Avalide®	☐
Benicar HCT® PREFERRED	☐
Hyzaar® PREFERRED	☐
Diovan HCT™	☐
Micardis HCT®	☐
Tevetan HCT®	☐

INDICATIONS FOR USE	YES	NO
1. Has the patient failed a 30 day trial of an Angiotensin Converting Enzyme Inhibitor: ACCUPRIL, ACCURETIC, ACEON, ALTACE, BENAZEPRIL, BENAZEPRIL-HCTZ, CAPOTEN, CAPTOPRIL, CAPTOPRIL/HCTZ, ENALAPRIL, ENALAPRIL/HCTZ, FOSINOPRIL, FOSINOPRIL-HCTZ, LISINOPRIL. LISINOPRIL-HCTZ, LOTENSIN, LOTENSIN HCT, MAVIK, MOEXIPRIL, MONOPRIL, MONOPRIL HCT, PRINIVIL, PRINZIDE, QUINAPRIL, QUINAPRIL-HCTZ, QUINARETIC, UNIRETIC, UNIVASC, VASERETIC, VASOTEC, ZESTORETIC, ZESTRIL; a) If No: Please explain why not AND attach Clinical Notes from Patient's Records ______________________________ ______________________________	☐	☐
2. Has the patient failed a 30 day trial of Hyzaar; a. If No: Please explain why not AND attach Clinical Notes from Patient's Records ______________________________ ______________________________	☐	☐
3. Has the patient failed a 30 day trial of Benicar HCT; a. If No: Please explain why not AND attach Clinical Notes from Patient's Records ______________________________ ______________________________	☐	☐

CONTRAINDICATIONS FOR USE	YES	NO
1. Patient has Bilateral Renal Artery Stenosis.	☐	☐
2. Patient is in 2nd or 3rd trimester.	☐	☐

References
1. Olin BR, ed. Drug Facts and Comparisons. Facts and Comparisons. St. Louis, 2006.
2. Lacy CF, Armstrong LL, et al. Lexi-Comp's Drug Information Handbook, 14th Ed. Hudson, OH 2006

PRESCRIBER SIGNATURE____________________________________ DATE______________

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.

BlueCross BlueShield of Vermont
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www.bcbsvt.com

Vermont Health PLAN