

Blue Cross Blue Shield of Vermont and The Vermont Health Plan

Prior Approval Form

Angiotensin Receptor Blockers

Atacand®, Avapro®, Benicar®, Cozaar®, Diovan™, Micardis®, and Tevetan®

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:	
Atacand®	<input type="checkbox"/>
Avapro®	<input type="checkbox"/>
Benicar® PREFERRED	<input type="checkbox"/>
Cozaar® PREFERRED	<input type="checkbox"/>
Diovan™	<input type="checkbox"/>
Micardis®	<input type="checkbox"/>
Tevetan®	<input type="checkbox"/>

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 _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Has the patient failed a 30 day trial of Cozaar; a) If No: Please explain why not AND attach Clinical Notes from Patient's Records _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the patient failed a 30 day trial of Benicar; a) If No: Please explain why not AND attach Clinical Notes from Patient's Records _____ _____	<input type="checkbox"/>	<input type="checkbox"/>
CONTRAINDICATIONS FOR USE	YES	NO
1. Patient has Bilateral Renal Artery Stenosis.	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient is in 2 nd or 3 rd trimester.	<input type="checkbox"/>	<input type="checkbox"/>

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.