Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Prior Approval Form
Exforge® (amlodipine and valsartan)

BCBSVT and TVHP Fax # (888)–255-1006

If approval criteria are met BCBSVT/TVHP will authorize coverage of Exforge® (amlodipine and valsartan) Thank you for your assistance.
PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request ___________________ Patient Name: _____________________

BCBSVT/TVHP Member ID#:_______________ Date of birth: ____________________

Provider Name: _________________________ Provider Phone number:____________

Provider Fax number: ____________________ PCP Name: _______________________

INDICATIONS FOR USE	YES	NO
1) Is patient an adult with a diagnosis of hypertension?	☐	☐
2) Has patient failed a 30 day trial of thiazide diuretics plus ACEI in the past 120 days?	☐	☐
3) Has patient failed a 30 day trial of thiazide diuretics plus CCB in the past 120 days?	☐	☐
4) Has patient failed a 30 day trial of thiazide diuretics plus B-Blocker in the past 120 days?	☐	☐
5) Has patient failed a 30 day trial of thiazide diuretics plus ARB in the last 120 days?	☐	☐
6) Is patient pregnant?	☐	☐
7) Does patient have a hypersensitivity to Exforge® or any of its ingredients?	☐	☐

Dose: ________ Frequency: _________ Duration of Therapy: _________

PRESCRIBER SIGNATURE___________________________________ DATE______________

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

References
1. Package Insert, Exforge® Novartis Pharmaceuticals, East Hanover, New Jersey 07936
2 .The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. Aram, et al. JAMA. 2003:289:2560.).