Blue Cross Blue Shield of Vermont and The Vermont Health Plan
Step Therapy Form Angiotensin Receptor Blockers and Renin Inhibitors
Edarbi®, Edarbyclor®, Tekturna®, Tekturna HCT®,
BCBSVT and TVHP Fax # (888)–255-1006

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:

<table>
<thead>
<tr>
<th>Angiotensin Receptor Blockers</th>
<th>Renin Inhibitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edarbi®</td>
<td>Tekturna HCT®</td>
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<td>Edarbyclor®</td>
<td>Tekturna®</td>
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</tbody>
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INDICATIONS FOR USE

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, RAMIPRIL, TRANDOLAPRIL, UNIRETIC, UNIVASC, VASERETIC, VASOTEC, ZESTORETIC, ZESTRIL;
   OR a generic ARB
   Losartan, Losartan/HCTZ, Eprosartan, Eprosartan/HCTZ, Irbasartan, Irbasartan/HCTZ, Olmesartan, Olmesartan/HCTZ, Olmesartan/Amlodipine, Olmesartan/HCTZ/Amlodipine, Telmisartan, Telmisartan/HCTZ, Valsartan, Valsartan/HCTZ, Valsartan/Amlodipine/HCTZ?
   a) If No: Please explain why not

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