



Date _____

Client _____

PRIOR AUTH CRITERIA- Angiotensin II Receptor Blocker (ARB)/Combo's

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please indicate which agent is being requested:

STEP B*

- Atacand Atacand HCT
- Avapro Avalide
- Benicar Benicar HCT
- Micardis Micardis HCT

STEP C**

- Diovan Diovan HCT
- Cozaar Hyzaar
- Teveten Teveten HCT
- Other Brand ACE/ACE Combo: _____

***Please note that if member is beginning therapy with an ARB, the member's benefit will only cover a generic ACE/ACE combo, unless the member has already tried and failed an ACE/ACE combo**

****Please Note that Step C drugs will not be approved unless all Step B drugs have been tried and failed**

2. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of an ACE Inhibitor or ACE Inhibitor Combination? Yes No

3. Please explain the reason for failure or non-trial, and attach notes from the patient's chart as documentation.

4. Does the patient have Bilateral Renal Artery Stenosis? Yes No

5. Is the patient in the 2nd or 3rd trimester of pregnancy? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906