



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTH QUESTIONNAIRE-EXFORGE®

*M.D. Last Name:* \_\_\_\_\_ *M.D. First Name:* \_\_\_\_\_

*Physician Phone:* \_\_\_\_\_ *Physician Fax:* \_\_\_\_\_

*Patient* \_\_\_\_\_ *ID#* \_\_\_\_\_ *DOB* \_\_\_\_\_

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

1. Diagnosis:
  - Hypertension
  - Other (please specify): \_\_\_\_\_
  
2. Is the patient pregnant or breastfeeding? Yes    No
  
3. Is the patient currently stable on the medication? Yes    No
  - a. If Yes, provide the date therapy was initiated \_\_\_\_\_
  - b. If No, proceed to Question #4
  
4. Has the patient tried and failed an ACE-Inhibitor? Yes    No
  - a. If Yes, specify drug and dates of trial \_\_\_\_\_
  - b. If No, provide the rationale for non-trial \_\_\_\_\_
  
5. Has the patient tried and failed Lotrel® (benazepril/amlodipine)? Yes    No
  - a. If Yes, provide dates of trial \_\_\_\_\_
  - b. If No, provide the rationale for non-trial \_\_\_\_\_
  
6. Indicate dose requested:
 

<input type="checkbox"/> Exforge 5-160 mg	<input type="checkbox"/> Exforge 10-160 mg
<input type="checkbox"/> Exforge 5-320 mg	<input type="checkbox"/> Exforge 10-320 mg
<input type="checkbox"/> Other (please specify): _____	
  
7. Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

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

**RESTAT**  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

**QUESTIONS PLEASE CALL:**  
**877-526-9906**

[www.restat.com](http://www.restat.com)