



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
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

www.restat.com