



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE- EXFORGE®/AZOR™

<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 patient's diagnosis:

- Hypertension
- Other diagnosis: _____
 Note: If Other diagnosis is used, please attach a study with efficacy data supporting this request

2. Is this product being used for initial therapy for hypertension? Yes No

3. List dates, and attach chart notes to document member's failure on an ACE-inhibitor:

ACE-inhibitor Used/Failed: _____

Dates used: _____

4. List dates, and attach chart notes to document member's failure on Lotrel® or generic benazepril/amlodipine:

Dates used: _____

5. Is the patient pregnant? Yes No

6. Does the patient have a hypersensitivity to any of the components of Exforge®/Azor™? 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

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906