

**State of Idaho, Division of Medicaid
 ANGIOTENSIN II RECEPTOR ANTAGONISTS (ARBs)
 PRIOR AUTHORIZATION FORM
 *CONFIDENTIAL INFORMATION***

Phone: 1-208-364-1829

One drug per form ONLY – Use black or blue ink

Fax: 1-208-364-1864

Patient Name: _____	Medicaid ID#: _____	Date of Birth: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store #: _____	Pharmacy Phone: _____	Pharmacy Fax: _____

Diovan[®], Diovan HCT[®], Benicar, Benicar HCT[®], Micardis[®], Micardis HCT[®], Cozaar[®], Hyzaar[®], Avapro[®] Avalide[®] are preferred agents and will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.

Teveten[®], Teveten HCT[®], Atacand[®] and Atacand HCT[®] will be approved for payment only after documented failure within the last 6 months of one of the preferred agents listed above.

Medication Requested:

Diovan[®]	NO PA REQUIRED	Cozaar[®]	NO PA REQUIRED
Diovan HCT[®]	NO PA REQUIRED	Hyzaar[®]	NO PA REQUIRED
Benicar[®]	NO PA REQUIRED	Avapro[®]	NO PA REQUIRED
Benicar HCT[®]	NO PA REQUIRED	Avalide[®]	NO PA REQUIRED
Micardis[®]	NO PA REQUIRED		
Micardis HCT[®]	NO PA REQUIRED		

<u>Drug</u>	<u>Strength</u>	<u>Instructions</u>
<input type="checkbox"/> Teveten [®]	_____	_____
<input type="checkbox"/> Teveten HCT [®]	_____	_____
<input type="checkbox"/> Atacand [®]	_____	_____
<input type="checkbox"/> Atacand HCT [®]	_____	_____

History of other ARB trials:

<u>Drug</u>	<u>Date(s) of Trial</u>	<u>Reason(s) for Failure</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

To ensure continuity of care, please make sure corresponding ICD-9 diagnosis codes are submitted on professional office claims to Medicaid on a routine basis.

Prescriber Signature: _____ **Date:** _____

By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.

For Medicaid Office Use Only

Date: _____	RPh: _____	Tech: _____	PA#: _____
Approved	Denied	Comments:	