Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Entresto® (sacubitril-valsartan)
Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if request is for initial trial ❑ Check if request is for recertification of therapy	Directions for Use:	

Clinical Information (required)

- ❑ The recipient has a diagnosis of chronic heart failure.
- ❑ The recipient is 1 year of age or older.
- ❑ The recipient will not be treated concurrently with an Angiotensin-converting enzyme (ACE) inhibitor.
- ❑ The recipient is currently receiving an individualized dose of a beta blocker or has a contraindication to beta blocker use.
- ❑ The requested dose is one tablet twice daily.
- ❑ The requested dose does not exceed 97 mg/103 mg twice daily.

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.