



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:	
<input type="checkbox"/> Check if request is for initial trial <input type="checkbox"/> Check if request is for recertification of therapy			Directions for Use:		
Clinical Information (required)					
<input type="checkbox"/> The recipient has a diagnosis of chronic heart failure. <input type="checkbox"/> The recipient is 1 year of age or older. <input type="checkbox"/> The recipient will not be treated concurrently with an Angiotensin-converting enzyme (ACE) inhibitor. <input type="checkbox"/> The recipient is currently receiving an individualized dose of a beta blocker or has a contraindication to beta blocker use. <input type="checkbox"/> The requested dose is one tablet twice daily. <input type="checkbox"/> 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.

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