



Antihypertensive Agents

**Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-251-5896**

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week, TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: medicarepartdparequests@express-scripts.com

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:
Is this medication a new start? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is this a continuation of therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION A

Please answer the following questions

1. Yes No Is the member currently taking the requested medication? *(If "No", proceed to question 3).*
2. Yes No Is the member stabilized on the current drug and does the member have a high risk of significant adverse clinical outcome with a medication change?
3. Yes No Has the member tried at least one of the following products: benazepril (or benazepril HCTZ or benazepril with amlodipine), captopril (or captopril HCTZ), enalapril (or enalapril HCTZ), fosinopril (or fosinopril HCTZ), lisinopril (or lisinopril HCTZ), moexipril (or moexipril HCTZ), perindopril, quinapril (or quinapril HCTZ), ramipril, trandolapril, losartan (or losartan HCT), irbesartan (or irbesartan HCT), or valsartan (or valsartan HCT or valsartan with amlodipine) for the current condition? *(If "Yes", skip question 4).*

4. Yes No Is any one of the following generic products likely to be ineffective or likely to cause an allergy/adverse reaction or other harm to the member: benazepril (or benazepril HCTZ or benazepril with amlodipine), captopril (or captopril HCTZ), enalapril (or enalapril HCTZ), fosinopril (or fosinopril HCTZ), lisinopril (or lisinopril HCTZ), moexipril (or moexipril HCTZ), perindopril, quinapril (or quinapril HCTZ), ramipril, trandolapril, losartan (or losartan HCT), irbesartan (or irbesartan HCT), or valsartan (or valsartan HCT or valsartan with amlodipine)?

Please document the symptoms and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1-877-251-5896

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Step Therapy criteria online at <http://www.scanhealthplan.com>