

Renin Angiotensin Antihypertensive Agents (RAAs) Prior Authorization Request Form



5628

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

PLEASE NOTE:

- **NO prior authorization is required for the preferred RAAs: losartan (Cozaar), losartan HCTZ (Hyzaar), Diovan, Diovan HCT, Exforge, Exforge HCT, Micardis, Micardis HCT, and Twynsta.**
- Prior authorization for the **non-preferred RAAs** Amlturnide, Atacand, Atacand HCT, Avapro, Avalide, Azor, Benicar, Benicar HCT, Edarbi, Edarbyclor, Tekamlo, Tekturna, Tekturna HCT, Teveten (eprosartan), Teveten HCT, Tribenzor, or Valturna is **NOT** required for patients who are currently receiving these medications **based on prescriptions filled during the last 6 months**, or if there has been a trial of a preferred RAA agent **based on prescriptions filled during the last 6 months**.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> • The provider may call: 1-866-684-4488 or the completed form may be faxed to: 1-866-684-4477 • The patient may attach the completed form to the prescription and mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954 or email the form only to: TpharmPA@express-scripts.com
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Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php

**Drug for which Prior Authorization
is requested:**

Step 1 Please complete patient and physician information (please print):

1	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

Step 2 Please complete the clinical assessment:

2 Preferred RAA agents are: losartan (Cozaar), losartan HCTZ (Hyzaar), Diovan, Diovan HCT, Exforge, Exforge HCT, Micardis, Micardis HCT, and Twynsta.		
1. Has the patient had a trial of one preferred RAA agent and was unable to tolerate treatment due to adverse effects?	Yes Please sign and date	No Proceed to Question 2
2. Has the patient had a trial of one preferred RAA agent and has had an inadequate response?	Yes Please sign and date	No Proceed to Question 3
3. Does the patient have a contraindication to the preferred RAA agents, which is not expected to occur with the non-preferred RAA agents (e.g., history of angioedema)?	Yes Please sign and date	No Coverage not approved

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature	Date
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