

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Diovan (valsartan) and
Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION
2. PHYSICIAN INFORMATION

| | |
|------------------------------|--------------------------------|
| Patient Name: _____ | Prescribing Physician: _____ |
| Patient ID #: _____ | Physician Address: _____ |
| Patient DOB: _____ | Physician Phone #: _____ |
| Date of Rx: _____ | Physician Fax #: _____ |
| Patient Phone #: _____ | Physician Specialty: _____ |
| Patient Email Address: _____ | Physician DEA: _____ |
| | Physician NPI #: _____ |
| | Physician Email Address: _____ |

3. MEDICATION
4. STRENGTH
5. DIRECTIONS
6. QUANTITY PER 30 DAYS

| | | | |
|--|--|--------------------|----------------|
| <input type="checkbox"/> Diovan (valsartan) <input type="checkbox"/> Diovan HCT (valsartan hydrochlorothiazide) | <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 160mg <input type="checkbox"/> 320mg <input type="checkbox"/> 80mg/12.5 <input type="checkbox"/> 160mg/12.5 <input type="checkbox"/> 320mg/12.5 <input type="checkbox"/> 160mg/25 <input type="checkbox"/> 320mg/25 | _____ _____ | Specify: _____ |
|--|--|--------------------|----------------|

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.
Diovan (valsartan)

- Yes No Patient has had a failure or intolerance to any Angiotensin Converting Enzyme inhibitor
 Yes No Patient has tried and failed Cozaar
 Yes No Patient is currently maintained on Diovan in the previous 90 days

Diovan HCT (valsartan hydrochlorothiazide)

- Yes No Patient has had a failure or intolerance to any Angiotensin Converting Enzyme inhibitor
 Yes No Patient has tried and failed Hyzaar
 Yes No Patient is currently maintained on Diovan HCT in the previous 90 days

9. PHYSICIAN SIGNATURE

| | |
|------------------------------------|-------|
| _____ | _____ |
| Prescriber or Authorized Signature | Date |

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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