



Step Therapy Request Form
Angiotension Renin Blocker (ARB) Step Therapy

Cozaar, Hyzaar

(Micardis (HCT), Avapro, Avalide, Diovan (HCT), Benicar (HCT)- see formulary for preferred products)

Patient Information **Prescriber Information**

Member Name:	Prescriber Name:
Bravo ID #	Prescriber Specialty:
DOB:	Prescriber Address:
Address:	
	Office Phone#:
	Office Fax #:
	Contact Person:

Diagnosis and Medication Requested

Medication Requested (dosage, frequency):	Qty:
Prescribing Diagnosis:	ICD9 Code
	Date Therapy Initiated:

Rationale for Step Therapy
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

1. Has the member experienced an inadequate response or intolerance with an Angiotension Converting Enzyme (ACE) Inhibitor?
Please provide rationale supporting request for Step Therapy.

- o Please provide clinical documentation supporting :
 - ◆ Name of alternate therapy, dates and duration of alternate therapy and outcome of each.

REQUIRED EXPLANATION:

Failure to provide clinical documentation supporting rationale may result in this request being denied

Request for Expedited Review

REQUEST FOR EXPEDITED REVIEW [24 HOURS]
BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Prescriber's Signature: _____ Date: _____

Fax back to: 866-464-0709 For info call: 877-813-5595
For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>