



**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>