

Pharmacy Medical Necessity Form

Last Reviewed: Jan. 07

For Prior Authorization please fax to: 616 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

BiDil[®] (isosorbide dinitrate/hydralazine hydrochloride)

Member Name: _____ Member #: _____ - _____

DOB: _____ Sex: _____ Provider Phone: _____

Provider Name: _____ Provider Fax: _____

Provider Office Contact Name: _____ Today's Date: _____

Indication:

For the treatment of heart failure as an adjunct to standard therapy in self-identified black patients to improve survival, to prolong time to hospitalization for heart failure, and to improve patient-reported functional status.

Precertification Requirements: (Check those that apply)

 Patient is African-American and has mild to moderate heart failure Diagnosis of NYHA-class IV heart failure Medications taken by patient: Diuretic: Name _____ Date _____ ACE's: Name _____ Date _____ ARB's: Name _____ Date _____ Cardiac Glycoside or Aldosterone Antagonist: Name _____ Date _____ Beta Blocker: Name _____ Date _____ Patient is not allergic to organic nitrates. Patient is not currently taking Phosphodiesterase-5 inhibitor drugs used for the treatment of erectile dysfunction or pulmonary hypertension.

For Internal Use Only

 Approved Denied Switch to: _____ Date Entered in Argus: _____

Effective Date: _____ End Date: _____ Fills: _____

Reviewed By: _____ Date: _____ Product: _____