

## ALISKIREN AGENTS (Tekturna/Tekturna HCT) PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines for Aliskiren Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Angiotensin Modulators and Angiotensin Modulator Combinations** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA#: _____)	# of pages in request: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

### CLINICAL INFORMATION

<b>Medication requested:</b> <input type="checkbox"/> Tekturna (aliskiren) <input type="checkbox"/> Tekturna HCT (aliskiren/HCTZ)			
Strength:	Directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):		Dx code ( <i>required</i> ):	
<b>Section A: All requests</b>			
1. Is the Recipient pregnant?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Does the Recipient have diabetes?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Will the Recipient be taking any of the following medications <u>in addition to</u> the requested medication? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <i>submit documentation of Recipient's complete current medication list</i> <input type="checkbox"/> No	
<input type="checkbox"/> an ACE inhibitor <input type="checkbox"/> cyclosporine <input type="checkbox"/> itraconazole <input type="checkbox"/> angiotensin receptor blocker (ARB) <input type="checkbox"/> high-dose diuretics			
4. Does the Recipient have a history of a hypersensitivity reaction to an ACE inhibitor or ARB?		<input type="checkbox"/> Yes – <i>submit documentation of drug and details of reaction</i> <input type="checkbox"/> No	
Complete <b>INITIAL</b> or <b>RENEWAL</b> section below.			
<b>Section B: Initial requests</b>			
1. Does the Recipient have a contraindication or intolerance to, or has the Recipient tried and failed drugs from the following drug classes, taken at maximally-tolerated FDA-approved doses? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen (drug name, strength, directions, and dates tried) and treatment outcome</i> <input type="checkbox"/> No	
<input type="checkbox"/> ACE inhibitors <input type="checkbox"/> beta blockers <input type="checkbox"/> diuretics <input type="checkbox"/> angiotensin receptor blockers (ARBs) <input type="checkbox"/> calcium channel blockers			
2. Were other causes of hypertension ruled out, including the following? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <i>submit documentation of differential diagnosis</i> <input type="checkbox"/> No	
<input type="checkbox"/> Cushing's syndrome <input type="checkbox"/> pheochromocytoma <input type="checkbox"/> hyperaldosteronism <input type="checkbox"/> renal artery stenosis			
3. Does the Recipient have results of baseline electrolytes and renal function tests?		<input type="checkbox"/> Yes – <i>submit test date and results</i> <input type="checkbox"/> No	
<b>Section C: Renewal requests</b>			
1. Does the Recipient have results of recent (since starting therapy) electrolytes and renal function tests?		<input type="checkbox"/> Yes – <i>submit test date and results</i> <input type="checkbox"/> No	

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

<b>Prescriber Signature:</b>	<b>Date:</b>
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