



Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ()	
BCBSLA Provider Number		Area of Practice/Specialty		Phone Number ()	

REQUESTED DRUG*

<input type="checkbox"/> Accupril®	<input type="checkbox"/> Capozide®	<input type="checkbox"/> Mavik®	<input type="checkbox"/> Tribenzor®
<input type="checkbox"/> Accuretic®	<input type="checkbox"/> Cozaar®	<input type="checkbox"/> Micardis®	<input type="checkbox"/> Twynsta®
<input type="checkbox"/> Aceon®	<input type="checkbox"/> Diovan®	<input type="checkbox"/> Micardis HCT®	<input type="checkbox"/> Uniretic®
<input type="checkbox"/> Amturnide®	<input type="checkbox"/> Diovan HCT®	<input type="checkbox"/> Monopril®	<input type="checkbox"/> Univasc®
<input type="checkbox"/> Atacand®	<input type="checkbox"/> Edarbi®	<input type="checkbox"/> Monopril HCT®	<input type="checkbox"/> Valturna®
<input type="checkbox"/> Atacand HCT®	<input type="checkbox"/> Edarbyclor®	<input type="checkbox"/> Prinivil®	<input type="checkbox"/> Vaseretic®
<input type="checkbox"/> Altace®	<input type="checkbox"/> Exforge®	<input type="checkbox"/> Prinzide®	<input type="checkbox"/> Vasotec®
<input type="checkbox"/> Avalide®	<input type="checkbox"/> Exforge HCT®	<input type="checkbox"/> Tarka®	<input type="checkbox"/> Zestril®
<input type="checkbox"/> Avapro®	<input type="checkbox"/> Hyzaar®	<input type="checkbox"/> Tekamlo®	<input type="checkbox"/> Zestoretic®
<input type="checkbox"/> Azor®	<input type="checkbox"/> Lexxel®	<input type="checkbox"/> Tekturma®	<input type="checkbox"/> Other _____
<input type="checkbox"/> Benicar®	<input type="checkbox"/> Lotensin®	<input type="checkbox"/> Tekturma HCT®	
<input type="checkbox"/> Benicar HCT®	<input type="checkbox"/> Lotensin HCT®	<input type="checkbox"/> Teveten®	
<input type="checkbox"/> Capoten®	<input type="checkbox"/> Lotrel®	<input type="checkbox"/> Teveten HCT®	

PAST TREATMENT HISTORY (Check ALL that apply)

<input type="checkbox"/> Amlodipine/Benazepril	<input type="checkbox"/> Edarbi®	<input type="checkbox"/> Micardis HCT®
<input type="checkbox"/> Atacand®	<input type="checkbox"/> Edarbyclor®	<input type="checkbox"/> Moexipril
<input type="checkbox"/> Atacand HCT®	<input type="checkbox"/> Exforge®	<input type="checkbox"/> Moexipril/HCTZ
<input type="checkbox"/> Avalide®	<input type="checkbox"/> Exforge HCT®	<input type="checkbox"/> Perindopril
<input type="checkbox"/> Avapro®	<input type="checkbox"/> Enalapril	<input type="checkbox"/> Quinapril
<input type="checkbox"/> Azor®	<input type="checkbox"/> Enalapril/HCTZ	<input type="checkbox"/> Quinapril/HCTZ
<input type="checkbox"/> Benazepril	<input type="checkbox"/> Fosinopril	<input type="checkbox"/> Quinaretic®
<input type="checkbox"/> Benazepril/HCTZ	<input type="checkbox"/> Fosinopril/HCTZ	<input type="checkbox"/> Ramipril
<input type="checkbox"/> Benicar®	<input type="checkbox"/> Hyzaar®	<input type="checkbox"/> Teveten®
<input type="checkbox"/> Benicar HCT®	<input type="checkbox"/> Lisinopril	<input type="checkbox"/> Teveten HCT®
<input type="checkbox"/> Captopril	<input type="checkbox"/> Lisinopril/HCTZ	<input type="checkbox"/> Trandolapril
<input type="checkbox"/> Captopril/HCTZ	<input type="checkbox"/> Losartan	<input type="checkbox"/> Trandolapril/Verapamil
<input type="checkbox"/> Cozaar®	<input type="checkbox"/> Losartan/HCTZ	<input type="checkbox"/> Twynsta®
<input type="checkbox"/> Diovan®	<input type="checkbox"/> Micardis®	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diovan HCT®		

OTHER CLINICAL INFORMATION (Check ALL that apply)

Yes No Does the patient have type 2 diabetes with hypertension and renal insufficiency?

Yes No Has the patient been hospitalized and discharged within the previous 30 days for CV event and started and stabilized on requested the medication?

Yes No Does the patient have gout or high serum uric acid levels?

Yes No Does the patient have Marfan Syndrome?

Yes No Is there clinical evidence or patient history that suggests the step 1 medication will be ineffective or cause an adverse reaction to the patient? _____

PHYSICIAN SIGNATURE _____ Prescribing Physician	DATE _____
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*Preferred brand drugs (Tier 2) are designated in bold.

Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed