PRIOR AUTHORIZATION REQUEST

Furoscix

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the patient currently receiving the requested medication? [If no, skip to question 5.]	Yes	No
2	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 5.]	Yes	No
3	Does the patient have a previously approved PA on file with the current plan for the requested medication? [If no, skip to question 5.]	Yes	No

If you have any questions, call: 1-888-258-8250

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4	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
5	What is the indication or diagnosis? [] Chronic heart failure New York Heart Association (NYHA) Class II or III (If checked, go to 6) [] Other (If checked, no further questions)		
6	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
7	Is the medication prescribed by or in consultation with a cardiologist? [If no, no further questions.]	Yes	No
8	Is the patient showing signs of extracellular volume expansion defined by one of the following: A) Jugular venous distention, B) Pitting edema (greater than or equal to 1+), C) Abdominal distention, D) Pulmonary congestion on chest X-ray, E) Pulmonary rales? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Has the patient been refractory to TWO of the following oral loop diuretics, at up to maximally tolerated doses: A) furosemide, B) torsemide, C) bumetanide? [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that within the last 60 days patient is a candidate for parenteral diuresis? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
11	Has the patient been diagnosed with hepatic cirrhosis or ascites? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
12	Will the patient be monitored for fluid, electrolyte, and metabolic abnormalities throughout therapy? [If no, no further questions.]	Yes	No
13	Will the patient be transitioned to oral diuretics as soon as possible and the requested medication will not be used for chronic treatment (chronic treatment defined as longer than 2 months)? [If no, no further questions.]	Yes	No
14	Does the dose exceed FDA approved label dosing for the indication?	Yes	No

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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