Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ________________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _______________________

Physician Fax #: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

# Horizon NJ Health

## *Entresto – Medical Necessity Request*

1. Does the member have chronic heart failure?
   - ☐ Yes
   - ☐ No - What is the member's diagnosis? ______________________________________________________________

2. What New York Heart Association Heart failure class does the member have?
   - ☐ Class I
   - ☐ Class II
   - ☐ Class III
   - ☐ Class IV

3. Does the member have reduced ejection fraction?
   - ☐ Yes
   - ☐ No

4. Please provide any other relevant clinical information:

_____________________________________________________________________________________________

5. Please list all medications the member has used for the given diagnosis, trial dates, and discontinuation reasons (or reason why Entresto must be added to current therapy).

| **Drug Name** | **Dates Tried** | **Discontinuation Reason** (or reason why Entresto must be added) |
|---|---|---|
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**Physician office's signature*_________________________________ Print Name________________________________**

***Form must be completed and signed by physician or licensed representative from the physician's office**