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)

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**