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 heart failure?
   - □ Yes
   - □ No - What is the member's diagnosis? _____
2. Is the member's heart failure acute or chronic?
   - □ Acute
   - □ Chronic
3. What New York Heart Association Heart failure class does the member have?
   - □ Class I
   - □ Class II
   - □ Class III
   - □ Class IV
4. Does the member have reduced ejection fraction?
   - □ Yes
   - □ No
5. Please provide any other relevant clinical information:

_____

Physician office's signature*_____ Print Name_____

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