Reset Form

New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Direct Renin Inhibitor and Combination Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

Patient's Name

Medicaid Number

Date of Birth (MM/DD/YYYY) / /

Gender ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: CLINICAL HISTORY

1. **Is the medication being prescribed for the treatment of hypertension?** ☐ Yes ☐ No
2. **If no, please provide patient diagnosis for use of this medication:** _____
3. **Is the patient 18 years of age or older?** ☐ Yes ☐ No
4. **If female, is the patient pregnant?** ☐ Yes ☐ No
5. **Has the patient failed a trial or past therapy with an angiotensin converting enzyme (ACE) Inhibitor or an angiotensin receptor blocker (ARB)?** ☐ Yes ☐ No

Please describe treatment failures and provide dates:

6. **Will the patient continue concurrent therapy with an ACE inhibitor or an ARB beyond 30 days?** ☐ Yes ☐ No

   If yes, document patient's most recent glomerular filtration rate (GFR) _____ ml/min

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

SECTION III: PRESCRIBER INFORMATION

Name

NPI Number

Prescriber Phone Number -

Prescriber Fax Number -

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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