



**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

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. Is the medication being prescribed for the treatment of hypertension? Yes No
 - a. If **no**, please provide patient diagnosis for use of this medication: _____
2. Is the patient 6 years of age or older **AND** weigh at least 20 kg? Yes No
3. Is the patient pregnant? Yes No
4. Has the patient failed a trial or past therapy with an angiotensin converting enzyme (ACE) Inhibitor and an angiotensin receptor blocker (ARB)? Yes No
 - a. Please describe treatment failures and provide dates: _____

(Form continued on next page.)



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (Continued)

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

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: _____