AmeriHealth Caritas™
New Hampshire

# Direct Renin Inhibitor and Combination Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

| Patient information and medication requested | |
|---|---|
| Patient's name: | Medicaid number: |
| Date of birth: | Gender: |
| Drug name: | Strength: |
| Dosing directions: | Length of therapy: |

| Prescriber information | |
|---|---|
| Prescriber last name: | Prescriber first name: |
| Prescriber address: | Prescriber representative: |
| NPI number: | |
| Phone #: | Fax #: |

| Clinical history |
|---|
| 1. Is the medication being prescribed for the treatment of hypertension? ☐ Yes ☐ No<br>If no, please provide patient diagnosis for use of this medication: |
| 2. Is the patient 18 years of age or older? ☐ Yes ☐ No |
| 3. If female, is the patient pregnant? ☐ Yes ☐ No |
| 4. 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: |
| 5. Will the patient continue concurrent therapy with an ACE inhibitor or an ARB beyond 30 days? ☐ Yes ☐ No<br><br>If yes, document patient's most recent glomerular filtration rate (GFR): _____ml/min |
| Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet. |

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

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.