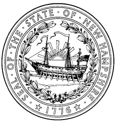

New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form

Direct Renin Inhibitor and Combination Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

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.)

Phone: 1-800-424-7901
Fax: 1-800-424-7984

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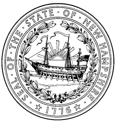

New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form
Direct Renin Inhibitor and Combination Medications

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME: **PATIENT FIRST NAME:**

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:** ________________

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