



**Direct Renin Inhibitor &
Combination Medications**
New Hampshire Medicaid Prior Authorization Request Form



Fax: 1-888-603-7696 Phone: 1-866-675-7755

Date of Medication Request: ____/____/____

Section I: Patient Information and Medication Requested:

Name: (Last, First) _____	NH Medicaid Number: _____
Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

Section II: Clinical History:

1. Is the medication being prescribed for the treatment of hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If no, please provide patient diagnosis for use of this medication: _____	
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. If female, is the patient pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has the patient failed a trial or past therapy with an angiotensin converting enzyme (ACE) Inhibitor or an angiotensin receptor blocker (ARB)?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, document patient's most recent glomerular filtration rate (GFR), _____ ml/min	
7. Does the patient have a diagnosis of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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:

Print Name: _____	NPI Number: _____
Phone Number: (____) _____ - _____	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.	
_____ Signature of Prescribing Provider	