maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Direct Renin Inhibitors

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	What is the diagnosis or indication? [] Hypertension (HTN) (If checked, go to 2) [] Other (If checked, no further questions)		
2	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
3	Has the patient experienced an inadequate response or inability to tolerate a trial of a formulary angiotensin receptor blocker (ARB) and angiotensin-converting enzyme (ACE) inhibitors?	Yes	No

If you have any questions, call:
1-888-258-8250

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	[NOTE: The formulary angiotensin receptor blockers (ARBs) include: losartan, losartan/HCTZ, irbesartan, valsartan/HCTZ, candesartan, candesartan/HCTZ, valsartan, valsartan/HCTZ, amlodipine/valsartan; amlodipine/valsartan/HCTZ. The formulary angiotensin-converting enzyme (ACE) inhibitors include: lisinopril, lisinopril/HCTZ, benazepril, benazepril/HCTZ, captopril, captopril/HCTZ, enalapril, enalapril/HCTZ, fosinopril, fosinopril/HCTZ, quinapril, quinapril/HCTZ, ramipril, perindopril, amlodipine/benazepril, moexipril, moexipril/HCTZ, trandolapril.] [If no, no further questions.]		
4	Has the patient experienced an inadequate response or inability to tolerate AT LEAST ONE other formulary antihypertensive agent from a different therapeutic class: thiazide-type diuretic, calcium channel blocker, and beta-blocker? [NOTE: Formulary thiazide-type diuretics include: chlorothiazide, Diuril, HCTZ, indapamide, methyclothiazide, metolazone. Formulary calcium channel blockers include: diltiazem, diltiazem ER, nifedipine, nifedipine ER, verapamil, verapamil ER, amlodipine, isradipine, nicardipine, nimodipine, felodipine ER, nisoldipine ER, Cartia XT, Taztia XT, Nifedical XL, Afeditab CR, Nifediac CC, Dilt-SR. Formulary beta-blockers include: atenolol, atenolol/chlorthalidone, bisoprolol, bisoprolol/HCTZ, carvedilol, metoprolol tartrate, metoprolol succinate, metoprolol/HCTZ, nadolol, nadolol/bendroflumethiazide, pindolol, propranolol, propranolol ER, propranolol/HCTZ, sotalol, sotalol (AF), timolol, acebutolol, betaxolol, labetalol.] [If no, no further questions.]	Yes	No
5	Is this medication being used in combination with an angiotensin-converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB)?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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