



**ACE-Inhibitors (ACE-I), Angiotensin II  
Receptor Blockers (ARB) and  
Renin Inhibitor  
PA Form**

<b>Fax Completed Form to: 866-254-0761 For questions regarding this Prior authorization, call 866-773-0695</b>
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Prior Authorization Vendor for ND
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ND Medicaid requires that patients receiving a prescription for Aceon must try at least two generic ACE-Is as first line.  
ND Medicaid requires that patients receiving an ARB or Renin Inhibitor must try and fail one ACE-I.

- \*Note:**
- **ACE-I: Captopril, enalapril, moexipril, ramipril, lisinopril, trandolapril, quinapril, benazepril, and fosinopril and their hydrochlorothiazide containing combinations do not require a prior authorization.**
  - **Angiotensin II receptor antagonists: Cozaar, Micardis, Teveten, Atacand, Diovan, Avapro, Benicar and their hydrochlorothiazide containing combinations.**
  - **Renin Inhibitor: Tekturna and Tekturna HCT.**

**Part I: TO BE COMPLETED BY PRESCRIBER**

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Prescriber Name					
Prescriber Medicaid Provider Number			Telephone Number		Fax Number
Address		City		State	Zip Code
<b>Requested Drug and Dosage:</b>			<b>Diagnosis for this request:</b>		
<b>Qualifications for coverage:</b>					
<input type="checkbox"/> Failed ACE-I therapy (list two ACE-I to receive Aceon)	Start Date	End Date	Dose	Frequency	
<input type="checkbox"/> I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.					
Prescriber Signature				Date	

**Part II: TO BE COMPLETED BY PHARMACY**

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #		

**Part III: FOR OFFICIAL USE ONLY**

Date Received			Initials:		
Approved - Effective dates of PA: From:     /     / To:     /     /			Approved by:		
Denied: (Reasons)					