

**State of Idaho, Division of Medicaid**

**ACE INHIBITORS**

**PRIOR AUTHORIZATION FORM**

*\*CONFIDENTIAL INFORMATION\**

**Phone: 1-208-364-1829** *One drug per form ONLY – Use black or blue ink* **Fax: 1-208-364-1864**

Patient Name: _____	Medicaid ID#: _____	D.O.B.: _____
Prescriber Name: _____	State License #: _____	Specialty: _____
Prescriber Phone: _____	Prescriber Fax: _____	
Pharmacy/Store#: _____	Phone: _____	Fax: _____

*Preferred agents will be approved for payment without prior authorization for eligible participants within the approved dosage quantities and age limits.*

*Non-preferred agents will be approved for payment only after documented failure of 1 preferred agent.*

**Medication Requested:**

**Preferred Agents (NO PA REQUIRED):**

Benazepril (generic only)	NO PA REQUIRED	Enalapril/HCTZ (generic only)	NO PA REQUIRED
Benazepril/HCTZ (generic only)	NO PA REQUIRED	Lisinopril (generic only)	NO PA REQUIRED
Captopril (generic only)	NO PA REQUIRED	Lisinopril/HCTZ	NO PA REQUIRED
Captopril /HCTZ (generic only)	NO PA REQUIRED	Perindopril (Aceon®)	NO PA REQUIRED
Enalapril (generic only)	NO PA REQUIRED	Ramipril (Altace®)	NO PA REQUIRED

**Non-Preferred Agents:**

<u>Drug</u>	<u>Strength</u>	<u>Dosing Instructions</u>	<u>Drug</u>	<u>Strength</u>	<u>Dosing Instructions</u>
<input type="checkbox"/> Accupril®	_____	_____	<input type="checkbox"/> Moexipril	_____	_____
<input type="checkbox"/> Accuretic®	_____	_____	<input type="checkbox"/> Prinivil®	_____	_____
<input type="checkbox"/> Capoten®	_____	_____	<input type="checkbox"/> Prinzide®	_____	_____
<input type="checkbox"/> Capozide®	_____	_____	<input type="checkbox"/> Quinapril	_____	_____
<input type="checkbox"/> Fosinopril	_____	_____	<input type="checkbox"/> Univasc®	_____	_____
<input type="checkbox"/> Fosinopril/HCTZ	_____	_____	<input type="checkbox"/> Uniretic®	_____	_____
<input type="checkbox"/> Lotensin®	_____	_____	<input type="checkbox"/> Vaseretic®	_____	_____
<input type="checkbox"/> Lotensin/HCT	_____	_____	<input type="checkbox"/> Vasotec®	_____	_____
<input type="checkbox"/> Mavik®	_____	_____	<input type="checkbox"/> Zestoretic®	_____	_____
<input type="checkbox"/> Monopril®	_____	_____	<input type="checkbox"/> Zestril®	_____	_____

**History of preferred agent:**

<u>Drug</u>	<u>Dates of Trial</u>	<u>Reason(s) for Failure</u>
_____	_____	_____

**Other pertinent information for review:**

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**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*By signing, the prescriber agrees that documentation of above indication and medical necessity is available for review by Idaho Medicaid in patient's current medical chart.*

<b>For Medicaid Office Use Only</b>			
Date:	RPh:	Tech:	PA#:
Approved	Denied	Comments:	

All current PA forms and criteria for use are available at: [www.medicaidpharmacy.idaho.gov](http://www.medicaidpharmacy.idaho.gov) (PA Criteria & Forms)