Reset Form | Print Form

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Asthma/Allergy Immunomodulator

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. For what condition is this medication being prescribed? _____
2. Is a pulmonologist, allergist, or immunologist prescribing this medication, or has one of these specialists been consulted in this case? ☐ Yes ☐ No

For an asthma diagnosis request, complete questions 3–6.

3. Is the patient symptomatic despite taking medium-to-high dose of inhaled corticosteroids or oral steroids in combination with either a long-acting beta$_2$ agonist, a leukotriene modifier, or theophylline? ☐ Yes ☐ No

   If **yes**, please indicate which medication(s) patient is currently taking: ☐ LABA: _____

   ☐ Leukotriene receptor agonist: _____ ☐ Theophylline

(Form continued on next page.)

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Asthma/Allergy Immunomodulator

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(CONTINUED)*

4. Has the patient's allergy been confirmed by skin testing or *in vitro* activity to the allergen? ☐ Yes ☐ No
5. Is the patient poorly compliant on the current asthma treatment plan? ☐ Yes ☐ No
6. Is the patient an active smoker? ☐ Yes ☐ No

For a nasal polyps diagnosis request, complete question 7.

7. Has the patient had an inadequate response to nasal corticosteroids? ☐ Yes ☐ No

   If **yes**, please list the nasal corticosteroids below with the dates of therapy.

   _____

For a hypereosinophilic syndrome diagnosis request, complete questions 8–9.

8. Has the hypereosinophilic syndrome lasted 6 months or longer? ☐ Yes ☐ No
9. Have secondary causes been ruled out? ☐ Yes ☐ No

For a chronic spontaneous urticaria diagnosis request, complete question 10.

10. Has the patient had an inadequate response to a first- or second-generation antihistamine? ☐ Yes ☐ No

    If **yes**, please list the antihistamines below with the dates of therapy.

    _____

For a COPD diagnosis request, complete questions 11-14.

11. Is the baseline FEV-1% predicted between 30%–70%? ☐ Yes ☐ No
12. Is the patient's blood eosinophil result > 300 cells/mcL? ____ cells/mcL _____date ☐ Yes ☐ No

    Is the patient receiving maximal inhaled therapy (LAMA/LABA/ICS)? ☐ Yes ☐ No

    Start date: _____

    If **no**, provide reason patient has not received LAMA/LABA/ICS.

    _____

13. Is the patient inadequately controlled? 2 moderate exacerbations (oral corticosteroid or antibiotic) or 1 severe exacerbation (hospitalization or ER visit) in the last 12 months? ☐ Yes ☐ No
14. Is the patient an active smoker? ☐ Yes ☐ No

For a chronic spontaneous urticaria diagnosis request, complete question 10.

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Asthma/Allergy Immunomodulator

DATE OF MEDICATION REQUEST: / /

Provide any additional information that would help in the decision-making process. ***If additional space is needed, please use another page.***

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**: _____

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

Prime THERAPEUTICS