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# 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.)*


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**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

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*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

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