



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

Benign Prostatic Hyperplasia (BPH) Medications

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

- Patient's diagnosis for use of this medication: _____
- Has the patient failed a trial of an alpha blocker and an androgen hormone inhibitor? Yes No
 - Please list medications and dates of trials: _____
- Will the patient be on concurrent nitrate, alpha blocker, Revatio, Adcirca or guanylate cyclase stimulator? Yes No
- Is there 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

© 2021–2024 Prime Therapeutics Management LLC, a Prime Therapeutics LLC company

Review Date: 06/29/2023

