Reset Form Print Form

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

Bowel Disorder 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

1. Is the medication being prescribed for the treatment of chronic constipation? ☐ Yes ☐ No
   If **yes**, answer questions 5–8.
2. Is the medication being prescribed for the treatment of irritable bowel syndrome? ☐ Yes ☐ No
   If **yes**, go to question8.
3. Is the medication being prescribed for opioid-induced constipation? If **yes**, go to question 8. ☐ Yes ☐ No
   If **no**, list patient diagnosis for use of this medication: _____
4. Is the patient averaging less than three spontaneous bowel movements per week? ☐ Yes ☐ No
5. Has the patient been experiencing constipation symptoms for at least three months? ☐ Yes ☐ No
6. Has the patient failed a trial or past therapy with at least 60 mL/day of lactulose? ☐ Yes ☐ No
   (**Describe in question 10 field**).
7. Has the patient failed a trial or past therapy with polyethylene glycol (MiraLAX®)? ☐ Yes ☐ No
   (**Describe in question 10 field**).

Review Date: 06/10/2024

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PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(Continued)*

8. Does the patient have a history of mechanical gastrointestinal obstruction? ☐ Yes ☐ No
9. Is the patient pregnant? ☐ Yes ☐ No
10. Please describe treatment failure(s) and provide dates:

11. Provide any additional information that would help in the decision-making process.
If additional space is needed, please use a separate sheet.

SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction. **Describe reaction:**

_____

☐ Drug-to-drug interaction. **Describe reaction:**

_____

☐ Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**

_____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**

_____

☐ Age-specific indications. **Provide patient age and explain:**

_____

☐ Unique clinical indication supported by FDA approval or peer-reviewed literature. **Explain and provide a reference:**

_____

☐ Unacceptable clinical risk associated with therapeutic change. **Please explain:**

_____

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**: _____

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