



**New Hampshire Medicaid Fee-for-Service (FFS) Program**  
**Prior Authorization/Non-Preferred Drug Approval Form**  
Brand Name Multiple Source Prescription 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:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PHONE NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FAX NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

**SECTION III: CLINICAL HISTORY**

1. Has the patient experienced a therapeutic failure (inadequate response) to an "A" rated generic? ☐ Yes ☐ No

If so, please describe: \_\_\_\_\_

2. Has the patient experienced an adverse reaction to an "A" rated generic? ☐ Yes ☐ No

If so, please describe: \_\_\_\_\_

3. In the prescriber's opinion, does transition to another generic in the same therapeutic category represent an unacceptable risk to the patient? ☐ Yes ☐ No

If so, please describe: \_\_\_\_\_

4. Does the patient have an allergy to one of the components of the generic (i.e. dye)? ☐ Yes ☐ No

If so, please describe: \_\_\_\_\_

(Form continued on next page.)

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**Prior Authorization/Non-Preferred Drug Approval Form**  
Brand Name Multiple Source Prescription Medications

DATE OF MEDICATION REQUEST:     /     /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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**SECTION III: CLINICAL HISTORY (*Continued*)**

5. Has a MEDWATCH form been submitted to the FDA?

☐ Yes ☐ No

*NOTE: Do not submit form to Prime Therapeutics State Government Solutions. Information regarding the form can be found at: <http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm>*

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

**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:** \_\_\_\_\_