



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

## CNS Stimulant and ADHD/ADD Medication

**DATE OF MEDICATION REQUEST:** / /

<b>SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED</b>															
<b>LAST NAME:</b>						<b>FIRST NAME:</b>									
<b>MEDICAID ID NUMBER:</b>						<b>DATE OF BIRTH:</b>									
								-							
<b>GENDER:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female															
<b>Drug Name:</b>						<b>Strength:</b>									
<b>Dosing Directions:</b>						<b>Length of Therapy:</b>									
<b>SECTION II: PRESCRIBER INFORMATION</b>															
<b>LAST NAME:</b>						<b>FIRST NAME:</b>									
<b>SPECIALTY:</b>						<b>NPI NUMBER:</b>									
<b>PHONE NUMBER:</b>						<b>FAX NUMBER:</b>									
			-						-						
<b>SECTION III: CLINICAL HISTORY</b>															
1. What is the patient's diagnosis for use of this medication?															

1. What is the patient's diagnosis for use of this medication? \_\_\_\_\_
2. Does the patient have swallowing issues? (For Daytrana patch®, ProCentra®, and Xelstrym® only).  Yes  No
3. Does the patient have a history of low blood pressure or low heart rate? (For Kapvay® and Intuniv® only).  Yes  No
4. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.  Yes  No

***If you are requesting a non-preferred product, proceed to Section IV.***

## 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 unacceptable side effects or therapeutic failure. 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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