Reset Form Print Form

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

CNS Stimulant and ADHD/ADD Medication

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. 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**: _____

Phone: 1-866-675-7755 **Fax**: 1-888-603-7696

Review Date: 06/10/2024