



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:

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

MEDICAID ID NUMBER:

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

GENDER: ☐ Male ☐ Female

Drug Name:

FIRST NAME:

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

DATE OF BIRTH:

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

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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

SPECIALTY:

FIRST NAME:

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

NPI NUMBER:

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

PHONE NUMBER:

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

FAX NUMBER:

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

SECTION III: CLINICAL HISTORY

- What is the patient's diagnosis for use of this medication? _____
- Does the patient have swallowing issues? (*For Daytrana patch[®], ProCentra[®], and Xelstrym[®] only*). ☐ Yes ☐ No
- Does the patient have a history of low blood pressure or low heart rate? (*For Kapvay[®] and Intuniv[®] only*). ☐ Yes ☐ No
- 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

© 2021–2025 Prime Therapeutics Management LLC, a Prime Therapeutics LLC company

Review Date: 11/01/2025

