



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

Convenience Kits (Rx)

DATE OF MEDICATION REQUEST:        /        /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

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

FIRST NAME:

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

MEDICAID ID NUMBER:

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

DATE OF BIRTH:

				-					-				
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GENDER:

 Male

 Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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

FIRST NAME:

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

SPECIALTY:

NPI NUMBER:

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

PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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**SECTION III: CLINICAL HISTORY**

1. Patient's diagnosis for use of this medication (please be complete and use a separate sheet if additional space is required):

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2. Has the patient had a trial of the active ingredient or ingredients in the kit?

 Yes     No

3. Is the active ingredient as a separate prescription on short supply?

 Yes     No

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

*(Form continued on next page.)*





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DATE OF MEDICATION REQUEST:        /        /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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