



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

Epidermolysis Bullosa

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

- Is the prescriber a dermatologist or a geneticist, or has one been consulted? Yes No
- Filsuvez:** Has the patient been diagnosed with dystrophic or epidermolysis bullosa? Provide confirmation with one of the following: Yes No
 - Immunofluorescence mapping (IFM)
 - Transmission electron microscopy (TEM)
 - Genetic testing
- Filsuvez:** Does the patient have current evidence or history of squamous cell carcinoma in the area where treatment will be applied? Yes No

(Form continues on next page.)

