Reset Form Print Form

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

Horizant® 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. Does the patient have a diagnosis of restless leg syndrome? ☐ Yes ☐ No

   If yes, respond to questions 2–3.

2. Has the patient tried and failed gabapentin IR? ☐ Yes ☐ No

   a. If *yes*, list date taken and reason for failure:

(Form continued on next page.)

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

Review Date: 01/29/2024

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

3. Has the patient tried and failed or does patient have a contraindication to levodopa/carbidopa, pramipexole, or ropinirole? ☐ Yes ☐ No
   a. If *yes*, list medication failed, date taken, and reason for failure or list medication contraindicated with specific reasons for contraindication:

4. Does the patient have a diagnosis of postherpetic neuralgia? If yes, respond to questions 5 – 6. ☐ Yes ☐ No
5. Has the patient tried and failed gabapentin or a tricyclic antidepressant? ☐ Yes ☐ No
   a. If yes, list date taken and reason for failure:
6. Has the patient tried and failed pregabalin? ☐ Yes ☐ No
   a. If yes, list date taken and reason for failure:
7. Is there any additional information that would help in the decision-making process? **If additional space is needed, please use another page.**

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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