



# New Hampshire Medicaid Fee-for-Service (FFS) Program

## Prior Authorization

Medical Necessity Rationale Required

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 justification for this formulation or strength? **(Check all that apply.)**  Yes  No
- Contraindication to other available formulations or strengths
  - Co-morbidity that requires this formulation or strength
  - Unique patient circumstance that requires this formulation or strength

**Provide clinical documentation to support selection.**

2. Is there an unacceptable clinical risk associated with a therapeutic change?  Yes  No

If yes, provide an explanation with documentation:

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