



**New Hampshire Medicaid Fee-for-Service (FFS) Program**  
**Prior Authorization/Non-Preferred Drug Approval Form**  
 Movement Disorders

DATE OF MEDICATION REQUEST:    /    /

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

LAST NAME:

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FIRST NAME:

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

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:     Male     Female

Drug Name

Strength

Dosing Directions

Length of Therapy

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

				-					-						
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**SECTION III: CLINICAL HISTORY**

- Does the patient have a diagnosis of Huntington's Chorea?     Yes     No
- Does the patient have a diagnosis of Tardive Dyskinesia?     Yes     No
- Does the patient have a diagnosis of Tourette's Syndrome?     Yes     No
- Is the patient currently receiving tetrabenazine, deutetrabenazine, reserpine, valbenazine, or an MAOI?     Yes     No
- Is the patient pregnant?     Yes     No
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

**For Xenazine® Only: Proceed to Section IV.**

*(Form continues on next page.)*



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**Prior Authorization/Non-Preferred Drug Approval Form**  
 Movement Disorders

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: \_\_\_\_\_