Reset Form Print Form

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:

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 Huntington's Chorea? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Tardive Dyskinesia? ☐ Yes ☐ No
3. Does the patient have a diagnosis of Tourette's Syndrome? ☐ Yes ☐ No
4. Is the patient currently receiving tetrabenazine, deutetrabenazine, reserpine, valbenazine, or an MAOI? ☐ Yes ☐ No
5. Is the patient pregnant? ☐ Yes ☐ No
6. 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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PATIENT LAST NAME:

PATIENT FIRST NAME:

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:** _____

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