Reset Form Print Form

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

New Drug Product Medication Request

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 rationale for this request for restricted medication?

   ☐ Allergic reaction ☐ Drug-to-drug interaction

   Please describe the reaction:

2. Please provide information about any previous episodes of an unacceptable side effect or therapeutic failure.

   Please provide clinical information:

(Form continued on next page.)

Prime THERAPEUTICS™

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

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

3. Please provide information about any clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.

   Please provide clinical information:

4. Please provide information about any age-specific indications.

   Please provide patient age and explain:

5. Please provide information about any unique clinical indication supported by FDA approval or peer-reviewed literature.

   Please explain and provide a reference:

6. Please provide information about any unacceptable clinical risk associated with therapeutic change.

   Please explain:

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**: _____

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

Prime THERAPEUTICS™