



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

Niemann-Pick Disease Type C

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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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:

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

SECTION III: CLINICAL HISTORY

1. Is the prescriber a geneticist or specialist in Niemann-Pick Disease Type C or has one been consulted? ☐ Yes ☐ No
2. Does the patient have a diagnosis of Niemann-Pick Disease Type C? ☐ Yes ☐ No
If yes, was this confirmed with genetic analysis demonstrating mutation in NPC1 or NPC2 gene? ☐ Yes ☐ No
3. Is the patient experiencing disease-related neurological symptoms? ☐ Yes ☐ No
Please describe: _____
4. Aqneursa: Provide the patient's current weight in kg. _____
5. Miplyffa: Will the patient be using miglustat concurrently? ☐ Yes ☐ No

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Review Date: 06/05/2025





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RENEWAL:

1. Has the patient experienced any treatment-restricting adverse effects? ☐ Yes ☐ No

2. Has the patient benefited from the medication? ☐ Yes ☐ No

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:** _____