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

**DATE OF MEDICATION REQUEST:** / /

### SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

**LAST NAME:**

**FIRST NAME:**

**MEDICAID ID NUMBER:**

**DATE OF BIRTH:** – –

**GENDER:** ☐ Male ☐ Female

Note that the following drug classes require separate prior authorization: Antihyperkinesis, Atopic Dermatitis, Growth Hormones, Hematopoietic Agents, Hepatitis C Agents, Inhaled Insulins, Long-Acting Opioids, Non-Selective NSAIDs, Onychomycosis Agents, Opiate Dependence Treatment, Novel Antidepressants, Proton Pump Inhibitors, and Systemic Immunomodulators.

**Medical Diagnosis:**

**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: MEDICAL HISTORY

*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 ☐ Drug-to-drug interaction **Please describe reaction:**

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information:

☐ Age-specific indications. Please provide patient age and explain:

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please 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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