



New Hampshire Medicaid Fee-for-Service (FFS) Program

Prior Authorization/Non-Preferred Drug Approval Form

Pulmonary Arterial Hypertension – Phosphodiesterase Type-5 (PDE-5) Inhibitor Only

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:

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

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

1. For what condition is this medication being prescribed? _____
2. Is the prescriber a cardiologist or pulmonologist experienced in the diagnosis and treatment of pulmonary hypertension, OR has one of these specialists been consulted in this case? Yes No
3. Will the patient be on concurrent organic nitrates, guanylate cyclase stimulators, or other PAH medications? Yes No
4. Is the request for sildenafil? Yes No
 - a. If Yes, will there be concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/tenofovir/emtricitabine? Yes No
5. Is the patient unable to take oral tablets? Yes No
 - a. If Yes, please explain: _____

(Form continued on next page.)



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (CONTINUED)

Provide any additional information that would help in the decision-making process. *If additional space is needed, please use another page.*

If you are requesting a non-preferred product, complete Section IV. If not, then proceed to Prescriber’s Signature.

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 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:** _____