Reset Form Print Form

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

Rho Kinase Inhibitor

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. Has the patient had an adequate trial and failure (within the last 60 days) of a generic prostaglandin inhibitor or beta-adrenergic antagonist? ☐ Yes ☐ No

   a. If *Yes*, please list treatment failures and provide dates or concurrent treatment:

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

SECTION IV: FOR RENEWALS ONLY

1. Has the patient demonstrated efficacy (e.g., reduction in IOP)? ☐ 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**: _____