Reset Form Print Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form

Skin Disorders

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

Atopic Dermatitis Topical Therapy (1–5) – Other indications skip to *question 11*.

1. What is the patient's diagnosis or condition that this medication is being prescribed to treat?

2. What is the patient's age?

3. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? ☐ Yes ☐ No
   If **yes**, describe treatment failure, contraindication, or intolerance and provide date:

4. Has the patient been treated with a topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus) in the past? ☐ Yes ☐ No
   If **yes**, provide drug name and duration of therapy:

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PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

5. **Opzelura® only:** Has the patient been treated with a topical phosphodiesterase-4 inhibitor (e.g., crisaborole) in the past? ☐ Yes ☐ No
   If **yes**, provide drug name and duration of therapy:

Atopic Dermatitis Systemic Therapy (6–10)

6. Is a dermatologist, immunologist, or allergist prescribing this medication, **or** has one been consulted in this case? ☐ Yes ☐ No
7. What is the patient's age? _____
8. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? ☐ Yes ☐ No
   If **yes**, describe treatment failure, contraindication, or intolerance and provide date:
9. Has the patient been treated with a topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus) or a topical phosphodiesterase-4 inhibitor (e.g., crisaborole) in the past? ☐ Yes ☐ No
   If **yes**, provide drug name and duration of therapy:
10. Will the patient also receive therapy with any other monoclonal antibody biologic (e.g., tezepelumab, omalizumab, mepolizumab, reslizumab, dupilumab)? ☐ Yes ☐ No

Other Indications (11–14)

11. Does the patient have a diagnosis of nonsegmental vitiligo? ☐ Yes ☐ No
12. What is the patient's age? _____
13. Is the prescriber a dermatologist? ☐ Yes ☐ No
14. Provide any additional information that would help in the decision-making process.
    If additional space is needed, please use a separate sheet.

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PATIENT LAST NAME:

PATIENT FIRST NAME:

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. **Describe reaction:**

☐ Drug-to-drug interaction. **Describe reaction:**

☐ Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**

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

☐ Age-specific indications. **Provide patient age and explain:**

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