Reset Form Print Form

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

Stromectol® (ivermectin)

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. Does the patient have a diagnosis of scabies? ☐ Yes ☐ No

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

2. Does the patient have a diagnosis of parasitic infection? ☐ Yes ☐ No

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

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**: _____

Phone: 1-866-675-7755 **Fax**: 1-888-603-7696

Review date: 06/29/2023

Prime THERAPEUTICS™