



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

Allergen Extract Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

Patient's Name

Medicaid Number

Date of Birth (MM/DD/YYYY)

Gender

 Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: CLINICAL HISTORY

1. Please list diagnosis for which medication is needed:

2. Was allergen confirmed by positive skin test or *in vitro* testing for pollen specific IgE antibodies for approved indication? Yes No

3. Did patient experience a severe reaction post initial dose administration of medication requested? Yes No

4. Will the patient be on concomitant allergen immunotherapy? Yes No

5. Does the patient have a history of severe, unstable or uncontrolled asthma? Yes No

6. Does the patient have a history of eosinophilic esophagitis? Yes No

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

SECTION III: PRESCRIBER INFORMATION

Name

NPI Number

Prescriber Phone Number

Prescriber Fax Number

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: _____