Reset Form

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

Benign Prostatic Hyperplasia (BPH) Medications *(Currently Cialis® Only)*

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 Schedule

Length of Therapy

SECTION II: CLINICAL HISTORY

1. **Patient's diagnosis for use of this medication:**
2. **Has the patient failed a trial of an alpha blocker and an androgen hormone inhibitor?** ☐ Yes ☐ No

   Please list medications and dates of trials:

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

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**: _____

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Revision Date: 09/09/2015

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