Reset Form

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

Brand Name Multiple Source Prescription 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. **Has the patient experienced a therapeutic failure (inadequate response) to an "A" rated generic?** ☐ Yes ☐ No

   If so, please describe:

2. **Has the patient experienced an adverse reaction to an "A" rated generic?** ☐ Yes ☐ No

   If so, please describe:

3. **In the prescriber's opinion, does transition to another generic in the same therapeutic category represent an unacceptable risk to the patient?** ☐ Yes ☐ No

   If so, please describe:

4. **Does the patient have an allergy to one of the components of the generic (i.e. dye)?** ☐ Yes ☐ No

   If so, please describe:

5. **Has a MEDWATCH form been submitted to the FDA?** ☐ Yes ☐ No

   NOTE: Do not submit form to Magellan Medicaid Administration. Information regarding the form can be found at:
   http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm

   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**: _____

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

©2015, Magellan Health, Inc. All Rights Reserved.
Revision Date: 12/02/2015

Magellan Rx MANAGEMENT℠