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

Oral Isotretinoin 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 provide the diagnosis/condition this medication is being prescribed to treat:**

2. **Has the patient failed at least two conventional acne treatments?** ☐ Yes ☐ No

   Please list treatment failures and dates:

3. **Are patient and provider registered, and meet all the requirements of the iPLEDGE® risk management program; INCLUDING if appropriate, a confirmed negative serum pregnancy test and a plan for contraception in place?** ☐ Yes ☐ No

4. **Has patient used oral isotretinoin therapy in the past?** ☐ Yes ☐ No

   If yes, please provide medication names and dates:

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**: _____

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