



New Hampshire Medicaid
Preferred Drug List
Non-Preferred Drug Approval Form
Fax: 1-888-603-7696 Phone: 1-866-675-7755



Date of Medication Request: ____/____/____

Patient Information:

Name: (Last, First) _____ Medicaid Number: _____
Date of Birth: ____/____/____ Gender: Male Female

Medication Requested:

Note that the following drugs classes require separate prior authorization: Anti-Obesity agents, COX II, Onychomycosis agents, Proton Pump Inhibitors, Rheumatologic agents, and CNS Stimulants. Please use class specific form found on the DHHS website at: <http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.html>

Medical Diagnosis: _____
Drug Name: _____ Strength: _____
Dosing Instructions: _____ Length of Therapy: _____

Medical History:

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

- Allergic reaction Drug-to-drug interaction. Please describe reaction: _____
- Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____

- Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.
Please provide clinical information: _____

- Age specific indications. Please give patient age and explain. _____
- Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference. _____

- Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Prescriber Information:

Name: _____ NPI Number: _____
Phone Number: (____) _____ - _____ 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.