



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

Onychomycosis Agents

DATE OF MEDICATION REQUEST:      /      /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

<b>Patient's Name</b>	<b>Medicaid Number</b>
<input type="text"/>	<input type="text"/>
<b>Date of Birth (MM/DD/YYYY)</b>	<b>Gender</b>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Drug Name</b>	<b>Strength</b>
<input type="text"/>	<input type="text"/>
<b>Dosing Directions</b>	<b>Length of Therapy</b>
<input type="text"/>	<input type="text"/>

## SECTION II: CLINICAL HISTORY

- Patient's Diagnosis:** \_\_\_\_\_
- List pertinent laboratory test(s) or procedure(s) if applicable: KOH, PAS, Culture, etc.**

PROCEDURE	DATE OF PROCEDURE	FINDINGS
_____	____ / ____ / ____	_____
_____	____ / ____ / ____	_____
_____	____ / ____ / ____	_____
- Does the patient have immunosuppression, diabetes or significant peripheral vascular compromise?**  Yes     No  
If so, please list which diagnosis. \_\_\_\_\_
- Is the patient experiencing pain which limits normal activity?**  Yes     No
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.**  
\_\_\_\_\_  
\_\_\_\_\_

If you are requesting a non-preferred product, proceed to Section III. If not, then proceed to Section IV.

## SECTION III: NON-PREFERRED DRUG APPROVAL CRITERIA

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 provide patient age and explain: \_\_\_\_\_

Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference: \_\_\_\_\_

Unacceptable clinical risk associated with therapeutic change. Please explain: \_\_\_\_\_

## SECTION IV: PRESCRIBER INFORMATION

<b>Name</b>	<b>NPI Number</b>
<input type="text"/>	<input type="text"/>
<b>Prescriber Phone Number</b>	<b>Prescriber Fax Number</b>
<input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/>

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:** \_\_\_\_\_