Reset Form

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

Oral NSAIDs Legend 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. **Does the patient have a diagnosis of acute migraine attacks?** *If yes, go to Question #3*. ☐ Yes ☐ No
2. **Does the patient have a diagnosis of mild to moderate acute pain?** *If yes, go to Question #3*. ☐ Yes ☐ No
3. **Is the patient 18 years of age or older?** ☐ Yes ☐ No
4. **Has the patient experienced a treatment failure, or is not a candidate for, treatment with the following agents: diclofenac or NSAID products?** ☐ Yes ☐ No

   Please list treatment failure and dates:

5. **Has the patient experienced a treatment failure, or is not a candidate for, single product ingredients, esomeprazole and naproxen (for Vimovo request only)?** ☐ Yes ☐ No

   Please list treatment failure and dates:

6. **Does the patient have a history of gastrointestinal complications with oral NSAIDS?** ☐ Yes ☐ No
7. **Does the patient have a diagnosis of cluster headaches or require prophylactic therapy for migraine treatment?** ☐ Yes ☐ No
8. **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**: _____

**Phone**: 1-866-675-7755
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