



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

Non-Preferred Drug Approval Form

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

Patient's Name	Medicaid Number
<input type="text"/>	<input type="text"/>
Date of Birth (MM/DD/YYYY)	Gender
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female

SECTION II: 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	Strength
Drug Name	
Dosing Directions	Length of Therapy

SECTION III: 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 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

Name	NPI Number
<input type="text"/>	<input type="text"/>
Prescriber Phone Number	Prescriber Fax Number
<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:** _____