Reset Form

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

Proton Pump Inhibitor

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. **Patient's Diagnosis:** _____
2. **Have any recent GI procedures been performed?** *(check and complete all that apply)*

PROCEDURE	DATE OF PROCEDURE	FINDINGS
☐ Upper GI Series	_____ / _____ / _____	_____
☐ Barium Swallow	_____ / _____ / _____	_____
☐ Serum Gastrin	_____ / _____ / _____	_____
☐ Endoscopy	_____ / _____ / _____	_____
☐ Serum Secretion Stimulation Test	_____ / _____ / _____	_____

3. **Has patient had a failure (4-week trial) on an acute dose of an H2 Receptor Antagonist in the past two years?** ☐ Yes ☐ No
   If yes, name medication: _____ Date of Trial: _____ / _____ / _____
4. **Is the patient H. Pylori positive?** ☐ Yes ☐ No **Date**: _____ / _____ / _____
5. **Recurrent GERD symptoms on acute dose of H2 blockers or PPI > 4 weeks?** ☐ Yes ☐ No
   If yes, which one: _____
6. **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

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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