



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

Receptor Selective NSAID Medication

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
Drug Name	Strength
<input type="text"/>	<input type="text"/>
Dosing Directions	Length of Therapy
<input type="text"/>	<input type="text"/>

SECTION II: CLINICAL HISTORY

1. **Patient's diagnosis:** _____
2. **Is the patient 75 years of age or older?** Yes No
3. **Does the patient have a sulfonamide allergy?** Yes No
4. **Did the patient fail two or more receptor selective NSAID medications, one being a high affinity NSAID; e.g., Lodine® (Etodolac), Feldene® (Piroxicam), Voltaren® (Diclofenac) or Dolobid® (Diflunisal)?** Yes No
5. **Was the patient intolerant of:** Yes No
 - One receptor selective NSAID medication? Yes No
 - If Yes, check all that apply: Edema GI Symptoms Failure to control pain
 - A second receptor selective NSAID medication? Yes No
 - If Yes, check all that apply: Edema GI Symptoms Failure to control pain
6. **Indicate which of the following apply:** Yes No
 - Previous history of a GI bleed: Yes No Date: _____
 - Current use of oral corticosteroid: Yes No
 - Peptic Ulcer Disease: Yes No
 - Please list treatment failure and dates: _____

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: 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.

<input type="checkbox"/> Allergic reaction	<input type="checkbox"/> Drug-to-drug interaction	Please describe reaction: _____
<input type="checkbox"/> Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____		
<input type="checkbox"/> Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information: _____		
<input type="checkbox"/> Age specific indications. Please provide patient age and explain: _____		
<input type="checkbox"/> Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference: _____		
<input type="checkbox"/> Unacceptable clinical risk associated with therapeutic change. Please explain: _____		

