



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

Systemic Immunomodulators Medication

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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MEDICAID ID NUMBER:

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GENDER: Male Female

Drug Name:

FIRST NAME:

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DATE OF BIRTH:

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Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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SPECIALTY:

FIRST NAME:

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NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. Patient's diagnosis for use of this medication

(please be complete and use a separate sheet if additional space is required): _____

2. Previous failure, contraindication, or adverse reaction to methotrexate AND at least one DMARD (sulfasalazine, hydroxychloroquine, minocycline): (For diagnosis of Rheumatoid Arthritis only)

Yes No

3. Previous failure, contraindication, or adverse reaction to oral corticosteroid: (For diagnosis of Crohn's disease)

Yes No

4. Previous failure, contraindication, or adverse reaction to oral/rectal aminosalicilate AND oral corticosteroid AND azathioprine or mercaptopurine for three months: (For diagnosis of active ulcerative colitis)

Yes No

5. Previous failure, contraindication, or adverse reaction to topical psoriasis agents: (For diagnosis of severe chronic plaque psoriasis only)

Yes No

6. Previous failure, contraindication or adverse reaction to NSAIDs: (For diagnosis of ankylosing spondylitis)

Yes No

7. Previous failure, contraindication, or adverse reaction to methotrexate: (For diagnosis of psoriatic arthritis)

Yes No

8. Does the patient have a diagnosis of moderate to severe heart failure?

Yes No

9. Does the patient have a diagnosis of irritable bowel syndrome? (For Cosentyx only)

Yes No

10. Is the patient pregnant? (Female only)

Yes No

11. Is the patient currently on another systemic immunomodulator?

Yes No

If yes, list medication: _____

12. Is the patient HIV positive?

Yes No

13. Does the patient have irritable bowel syndrome (For Cosentyx only)?

Yes No

14. Is there any additional information that would help in the decision-making process?

Yes No

Fax to Magellan Rx Management if medications can be dispensed by a pharmacy and will be administered by the patient or caregiver in the home.

Phone: 1-866-675-7755

Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:

Phone: 1-603-271-9384

Fax: 1-603-271-8194



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FIRST NAME:

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SECTION IV: 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 describe reaction:** _____
- 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:** _____

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: _____