Reset Form

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

Topical Combinations Acne Products

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. **What is the condition that this medication is being prescribed for?**
2. **Has the patient failed a trial or past therapy with a single topical retinoid or benzoyl peroxide medication?** ☐ Yes ☐ No

   If YES, please list treatment failures and provide dates:

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

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
Fax: 1-888-603-7696

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