Reset Form

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

Topical Immunomodulators Medications

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. **Please provide the diagnosis/condition this medication is being prescribed to treat:**

2. **What is the patient's age?**

3. **Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy?** ☐ Yes ☐ No

   If YES, please describe treatment failure, contraindication, or intolerance and provide date:

4. **Has the patient been treated with a topical immunomodulator in the past?** ☐ Yes ☐ No

   If YES, please provide drug name and duration of therapy:

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**: _____

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