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

Xenical® for Hypercholesterolemia

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:**

   Note: Xenical® coverage for weight loss should be requested using the Anti-Obesity Prior Authorization Form.

2. **Is the patient 18 years of age or older?** ☐ Yes ☐ No

3. **Has the patient failed treatment due to an adverse event with?**

HMG CoA Reductase Inhibitors?	☐ Yes	☐ No	If yes, which one?
Fibric Acid Derivatives?	☐ Yes	☐ No	If yes, which one?
Bile Acid Derivatives?	☐ Yes	☐ No	If yes, which one?
Nicotinic Acid?	☐ Yes	☐ No	If yes, which one?

4. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page:

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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Magellan Rx MANAGEMENT