



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

Asthma/Allergy Immunomodulator

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- For what condition is this medication being prescribed? _____
- Is a pulmonologist, allergist, or immunologist prescribing this medication, or has one of these specialists been consulted in this case? Yes No
For asthma diagnosis request, complete questions 3–8.
- Is the patient symptomatic despite taking medium-to-high dose of inhaled corticosteroids or oral steroids in combination with either a long-acting beta₂ agonist, a leukotriene modifier, or theophylline? Yes No
 - If Yes, please indicate which medication(s) patient is currently taking: LABA: _____
 Leukotriene receptor agonist: _____ Theophylline

