



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

Huntington's Disease Medications

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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

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

- Does the patient have a diagnosis of Huntington's Chorea? Yes No
- Does the patient have untreated or inadequately treated depression or active suicidal ideation? Yes No
- Is the patient pregnant? Yes No
- Does the patient have a diagnosis of hepatic impairment? Yes No
- For Austedo® only:* Has the patient had trial and failure of tetrabenazine (generic)? Yes No
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

(Form continued on next page.)

