



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

Inhaled Insulin Medications

DATE OF MEDICATION REQUEST:     /     /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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

FIRST NAME:

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

MEDICAID ID NUMBER:

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

DATE OF BIRTH:

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

GENDER:    Male    Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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

FIRST NAME:

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

SPECIALTY:

NPI NUMBER:

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

PHONE NUMBER:

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

FAX NUMBER:

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

## SECTION III: CLINICAL HISTORY

- Please list recent FEV1 level and date taken: \_\_\_\_\_
- Does patient have concurrent diagnosis of COPD, asthma, or emphysema?      Yes    No
- Is the patient an active cigarette smoker?      Yes    No  
If NO to question 3, list date of last cigarette smoked: \_\_\_\_\_
- Does the patient have a diagnosis of Type 1 diabetes?      Yes    No  
If YES to question 4, has the patient had a history of treatment failure with fast acting SC insulin?      Yes    No  
If YES to question 4, will the patient be on concurrent use of a long acting insulin?      Yes    No
- Does the patient have a diagnosis of Type 2 diabetes?      Yes    No  
If YES to question 5, please provide patient's HgA1C: \_\_\_\_\_  
If YES to question 5, has the patient had a history of treatment failure with fast acting SC insulin?      Yes    No  
If YES to question 5, list maximum doses of sulfonylureas, metformin, and TZDs: \_\_\_\_\_
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.      Yes    No

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: \_\_\_\_\_