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

Oral Isotretinoin 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

1. Please provide the diagnosis/condition this medication is being prescribed to treat:
2. Has the patient failed at least two conventional acne treatments? ☐ Yes ☐ No

   Please list treatment failures and dates:
3. Are patient and provider registered to the iPLEDGE® risk management program and are all requirements met, INCLUDING, if appropriate, a confirmed negative serum pregnancy test and a plan for contraception in place? ☐ Yes ☐ No
4. Has patient used oral isotretinoin therapy in the past? ☐ Yes ☐ No

   If yes, please provide medication names and dates:
5. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

**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**: _____

**Phone**: 1-866-675-7755
**Fax**: 1-888-603-7696

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