



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

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:

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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

1. What is the rationale for this request for restricted medication?

Allergic reaction Drug-to-drug interaction

Please describe the reaction:

2. Please provide information about any previous episode of an unacceptable side effect or therapeutic failure.

Please provide clinical information:

(Form continued on next page.)



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FIRST NAME:

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3. Please provide information about any clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.

Please provide clinical information:

4. Please provide information about any age specific indications.

Please provide patient age and explain:

5. Please provide information about any unique clinical indication supported by FDA approval or peer reviewed literature.

Please explain and provide a reference:

6. Please provide information about any unacceptable clinical risk associated with therapeutic change.

Please explain:

7. 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:** _____