



# New Hampshire Medicaid Fee-for-Service (FFS) Program

## Prior Authorization/Non-Preferred Drug Approval Form

Anti-Fungal Medication for Onychomycosis

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. Patient's diagnosis: \_\_\_\_\_

2. List pertinent laboratory test(s) or procedure(s), if applicable (KOH, PAS, Culture, etc.):

PROCEDURE	DATE OF PROCEDURE	FINDINGS
_____	____/____/____	_____
_____	____/____/____	_____
_____	____/____/____	_____

3. Does the patient have immunosuppression, diabetes, or significant peripheral vascular compromise?  Yes  No

a. If Yes, please list which diagnosis: \_\_\_\_\_

4. Is the patient experiencing pain that limits normal activity?  Yes  No

Provide any additional information that would help in the decision-making process? *If additional space is needed, please use another page.*

If you are requesting a non-preferred product, complete Section IV. If not, then proceed to Prescriber's Signature.

### SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

CHAPTER 188 OF THE LAWS OF 2004 REQUIRES THAT MEDICAID ONLY COVER NON-PREFERRED DRUGS UPON A FINDING OF MEDICAL NECESSITY BY THE PRESCRIBING PHYSICIAN. CHAPTER 188 REQUIRES THAT YOU BASE YOUR DETERMINATION OF MEDICAL NECESSITY ON THE FOLLOWING CRITERIA.

Allergic reaction  Drug-to-drug interaction Please describe reaction: \_\_\_\_\_

Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: \_\_\_\_\_

Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information: \_\_\_\_\_

Age-specific indications. Please provide patient age and explain: \_\_\_\_\_

Unique clinical indication supported by FDA approval or peer-reviewed literature. Please explain and provide a reference: \_\_\_\_\_

Unacceptable clinical risk associated with therapeutic change. Please explain: \_\_\_\_\_

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

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Fax: 1-888-603-7696

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