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

Oral NSAIDs and Combination Legend (Rx Required) 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

For Cambia®, Zipsor®, and Zorvolex® answer questions 1-5 and 14

1. Does the patient have a diagnosis of acute migraine attacks? **If yes, go to Question #4.** ☐ Yes ☐ No
2. Does the patient have a diagnosis of mild to moderate acute pain? **If yes, go to Question #4.** ☐ Yes ☐ No
3. Does the patient have a diagnosis of cluster headaches or require prophylactic therapy for migraine treatment? ☐ Yes ☐ No
4. Is the patient 18 years of age or older? ☐ Yes ☐ No
5. Has the patient experienced a treatment failure, or is not a candidate for, treatment with the following agents: diclofenac or NSAID products? **Please list treatment failure and dates:** ☐ Yes ☐ No

(Form continued on next page.)

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LAST NAME: | | | | | | | | | | | | |

FIRST NAME: | | | | | | | | | | | | |

For combination products answer questions 6-8 and 14

6. Is the patient 18 years of age or older? ☐ Yes ☐ No
7. Has the patient experienced a treatment failure, or is not a candidate for, single product ingredients (esomeprazole and naproxen for Vimovo® request; ibuprofen and famotiding for Duexis® requests)? **Please list treatment failure and dates:** ☐ Yes ☐ No

   _____
8. Does the patient have a history of gastrointestinal complications with oral NSAIDS? ☐ Yes ☐ No

For Celebrex®, Mobic®, Qmiiz ODT™, Vivlodex™ answer questions 9-14

9. Is the patient of FDA-approved age for medication requested? ☐ Yes ☐ No
10. Has the patient experienced a treatment failure, or is not a candidate for two or more non-selective NSAIDs, one of which must be etodolac, disulfiram, diclofenac, or piroxicam? **Please list treatment failure and dates:** ☐ Yes ☐ No

    _____
    - One receptor selective NSAID medication?

      If YES, check all that apply: ☐ Edema ☐ GI Symptoms ☐ Failure to control pain
    - A second receptor selective NSAID medication?

      If YES, check all that apply: ☐ Edema ☐ GI Symptoms ☐ Failure to control pain
11. Does the patient have a sulfonamide allergy? ☐ Yes ☐ No
12. Is the patient in the perioperative period for coronary artery bypass graft (CABG) surgery? ☐ Yes ☐ No
13. Will there be concomitant use of warfarin or another NSAID? ☐ Yes ☐ No
14. 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**: _____

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Magellan Rx MANAGEMENT℠