Reset Form | Print Form

New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Pulmonary Arterial Hypertension – Phosphodiesterase Type-5 (PDE-5) Inhibitor Only

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. For what condition is this medication being prescribed? _____
2. Is the prescriber a cardiologist or pulmonologist experienced in the diagnosis and treatment of pulmonary hypertension, OR has one of these specialists been consulted in this case? ☐ Yes ☐ No
3. Will the patient be on concurrent organic nitrates, guanylate cyclase stimulators, or other PAH medications? ☐ Yes ☐ No
4. Is the request for sildenafil? ☐ Yes ☐ No
   a. If *Yes*, will there be concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/tenofovir/emtricitabine? ☐ Yes ☐ No
5. Is the patient unable to take oral tablets? ☐ Yes ☐ No
   a. If *Yes*, please explain: _____

(Form continued on next page.)

Phone: 1-866-675-7755
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Magellan Rx MANAGEMENT

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Prior Authorization/Non-Preferred Drug Approval Form
Pulmonary Arterial Hypertension – Phosphodiesterase Type-5 (PDE-5) Inhibitor Only

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:	**PATIENT FIRST NAME:**

SECTION III: CLINICAL HISTORY *(CONTINUED)*

Provide 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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