



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

Restless Leg Syndrome Medication

DATE OF MEDICATION REQUEST: / /

LAST NAME:

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FIRST NAME:

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SECTION III: CLINICAL HISTORY (Continued)

3. Has the patient tried and failed or have a contraindication to levodopa/carbidopa, pramipexole, Yes No or ropinirole?

If Yes, list medication failed, date taken, and reason for failure or medication contraindicated with specific reasons for contraindication:

4. 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:** _____