



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

Legend Topical NSAIDs Agents

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

Patient's Name

Medicaid Number

Date of Birth (MM/DD/YYYY)

Gender

Male

Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: CLINICAL HISTORY

- Is the patient 18 years of age or older? Yes No
- Has the patient tried and failed an oral generic diclofenac product? Yes No
- Has the patient tried and failed an oral generic NSAID product? Yes No
If yes to #3, list medication names _____
- Is the patient unable to swallow, tolerate, or absorb oral medications? Yes No
- Will the patient be on concurrent oral NSAIDs? Yes No
- Is the patient undergoing coronary artery bypass graft (CABG) surgery? Yes No
- Does the patient have a history of gastrointestinal contraindications to oral NSAIDs? Yes No

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

SECTION III: PRESCRIBER INFORMATION

Name

NPI Number

Prescriber Phone Number

Prescriber Fax Number

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: _____