AmeriHealth Caritas™
New Hampshire

Asthma/Allergy Immunomodulator

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
NPI number:		Specialty:	
Phone #:	Fax #:		

Clinical history
1. For what condition is this medication being prescribed?
2. Is a pulmonologist, allergist, or immunologist prescribing this medication, or has one of these specialists been consulted in this case? ☐ Yes ☐ No *For asthma diagnosis request, complete questions 3–9.*
3. Is the patient symptomatic despite taking medium-to-high dose of inhaled corticosteroids or oral steroids in combination with either a long-acting beta2 agonist, a leukotriene modifier, or theophylline? ☐ Yes ☐ No If yes, please indicate which medication(s) patient is currently taking: ☐ LABA: ☐ Leukotriene receptor agonist: ☐ Theophylline
4. Has the patient's allergy been confirmed by skin testing or in vitro activity to the allergen? ☐ Yes ☐ No
5. Is the patient's IgE result > 30 IU/mL and ≤ 700 IU/mL? ☐ Yes ☐ No _____IU/ml
6. Is the patient poorly compliant on the current asthma treatment plan? ☐ Yes ☐ No
7. Is the patient an active smoker? ☐ Yes ☐ No
8. Is this patient being treated exclusively for a peanut allergy? ☐ Yes ☐ No
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

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.