AmeriHealth Caritas New Hampshire

Atopic Dermatitis Medications

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. Please provide the diagnosis/condition this medication is being prescribed to treat:
2. What is the patient's age?
3. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? ☐ Yes ☐ No If yes, please describe the treatment failure, contraindication, or intolerance and provide the date:
4. Has the patient been treated with a topical immunomodulator in the past? ☐ Yes ☐ No If yes, please provide drug name and duration of therapy:
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.