AmeriHealth Caritas New Hampshire

Brand Name Multiple Source Prescription 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:		
Phone #:	Fax #:	

Clinical history
1.Has the patient experienced a therapeutic failure (inadequate response) to an "A" rated generic? ☐ Yes ☐ No If so, please describe:
2. Has the patient experienced an adverse reaction to an "A" rated generic? ☐ Yes ☐ No If so, please describe:
3. In the prescriber's opinion, does transition to another generic in the same therapeutic category represent an unacceptable risk to the patient? ☐ Yes ☐ No If so, please describe:
4. Does the patient have an allergy to one of the components of the generic (i.e. dye)? ☐ Yes ☐ No If so, please describe:
5. Has a MEDWATCH form been submitted to the FDA? ☐ Yes ☐ No NOTE: Do not submit form to Magellan Medicaid Administration. Information regarding the form can be found at: **http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm**
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.