AmeriHealth Caritas™
New Hampshire

Anti-Fungal Medication for Onychomycosis

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:
Specialty:	NPI number:
Phone #:	Fax #:

Clinical history

1. Patient's diagnosis:

2. List pertinent laboratory test(s) or procedure(s), if applicable (KOH, PAS, Culture, etc.):

Procedure	Date of procedure	Findings

3. Does the patient have immunosuppression, diabetes, or significant peripheral vascular compromise? ☐ Yes ☐ No
If yes, please list which diagnosis:

4. Is the patient experiencing pain that limits normal activity? ☐ Yes ☐ No

Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

If you are requesting a non-preferred product, proceed below.

Non-preferred drug approval criteria

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria.

☐ Allergic reaction
Please describe reaction:

☐ Drug-to-drug reaction
Please describe reaction:

☐ Previous episode of an unacceptable side effect or therapeutic failure.
Please provide clinical information:

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.
Please provide clinical information:

Non-preferred drug approval criteria (continued)
☐ Age specific indications. Please provide patient age and explain:
☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:
☐ Unacceptable clinical risk associated with therapeutic change. Please explain:

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.