AmeriHealth Caritas New Hampshire

Oral NSAIDs Legend 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. Does the patient have a diagnosis of acute migraine attacks? If yes, go to Question #3. ☐ Yes ☐ No
2. Does the patient have a diagnosis of mild to moderate acute pain? If yes, go to Question #3. ☐ Yes ☐ No
3. Is the patient 18 years of age or older? ☐ Yes ☐ No
4. Has the patient experienced a treatment failure, or is not a candidate for, treatment with the following agents: diclofenac or NSAID products? ☐ Yes ☐ No Please list treatment failure and dates:
5. Has the patient experienced a treatment failure, or is not a candidate for, single product ingredients, esomeprazole and naproxen (for Vimovo request only)? ☐ Yes ☐ No Please list treatment failure and dates:
6. Does the patient have a history of gastrointestinal complications with oral NSAIDS? ☐ Yes ☐ No
7. Does the patient have a diagnosis of cluster headaches or require prophylactic therapy for migraine treatment? ☐ 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.