AmeriHealth Caritas™
New Hampshire

Receptor Selective NSAID Medication

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

Clinical history

1. Patient's diagnosis:

2. Will there be concomitant use of warfarin or another NSAID? ☐ Yes ☐ No

3. Does the patient have a sulfonamide allergy? ☐ Yes ☐ No

4. Did the patient fail two or more receptor selective NSAID medications, one being a high affinity NSAID; e.g., Lodine® (etodolac), Feldene® (piroxicam), Voltaren® (diclofenac) or Dolobid® (diflunisal)? ☐ Yes ☐ No
Please list treatment failure and dates:

5. Was the patient intolerant of:

a. One receptor selective NSAID medication? ☐ Yes ☐ No

If yes, check all that apply: ☐ Edema ☐ GI symptoms ☐ Failure to control pain

b. A second receptor selective NSAID medication? ☐ Yes ☐ No

If yes, check all that apply: ☐ Edema ☐ GI symptoms ☐ Failure to control pain

Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Medical history

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 ☐ Drug-to-drug reaction
Please describe reaction:

☐ Previous episode of an unacceptable side effect or therapeutic failure.
Please describe reaction:

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

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Non-preferred drug approval criteria
☐ 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.