AmeriHealth Caritas New Hampshire

Restless Leg Syndrome

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. Does the patient have a diagnosis of Restless Leg Syndrome? ☐ Yes ☐ No
2. Has the patient tried and failed gabapentin IR? ☐ Yes ☐ No If yes, list date taken and reason for failure:
3. Has the patient tried and failed levodopa/carbidopa, pramipexole or ropinirole? ☐ Yes ☐ No If yes, please list medication that failed, date taken, and reason for failure:
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.