AmeriHealth Caritas New Hampshire

New Hampshire Medicaid Prior Authorization
Drug Approval Form

Date of medication request:

☐ Initial request

☐ Continuation/Renewal request

☐ Expedited review/Urgent request
(I attest that this urgent request meets the definition and criteria for expedited review.)

Section I: Patient Information and Medication Requested	
Last name:	First name:
Medicaid ID number:	Date of birth:
Gender: ☐ Male ☐ Female	
Certain drug classes may have additional prior authorization requirements.	
Reason for request (check all that apply): ☐ Prior authorization, step therapy, formulary exception ☐ Quantity exception ☐ Specialty drug ☐ Other (please specify):	
Medical diagnosis:	
Requested drug name:	Strength:
Dosing directions:	Quantity:
Length of therapy:	Date therapy initiated:
Is the patient currently being treated with the drug requested? ☐ Yes ☐ No If yes, date started:	
Has a MedWatch form been submitted to the FDA? ☐ Yes ☐ No	
Dispense as written (DAW) specified? ☐ Yes ☐ No	
Rationale for DAW:	
Is medication a compound? ☐ Yes ☐ No If medication is a compound, list ingredients:	
For compound or off-label use, include citation to peer-reviewed literature:	

Section II: Prescriber Information		
Last name:	First name:	
Specialty:	NPI number:	
Phone number:	Fax number:	
Prescriber point of contact name (POC) (if different than provider):		
POC phone number:	POC secure fax number:	
POC email (not required):		

Section III: Patient Medical History
Primary diagnosis related to medication request
ICD codes:
Pertinent comorbidities:
☐ Allergic reaction ☐ Drug-to-drug interaction Please describe reaction:
☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
☐ Unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information:
☐ Age-specific indications. Please provide 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:
If relevant to this request
Other drug allergies:
Height: Weight:
Pertinent concurrent medications:

If relevant to this request (continued)
Are there contraindications to alternative therapies? ☐ Yes ☐ No If yes, please list details:
Were non-pharmacologic therapies tried? ☐ Yes ☐ No If yes, please provide details:
If a renewal of medication, has the patient shown improvement in related condition while on therapy? ☐ Yes ☐ No If yes, please describe:
Opioid management tools in place:
☐ Risk assessment ☐ Informed consent ☐ Treatment plan ☐ Pain contract ☐ Pharmacy/prescriber restriction

Previous therapies tried and failed

Drug name	Strength	Dosing schedule	Date prescribed	Date stopped	Description of adverse reaction or failure	Check if a sample

Relevant lab values

Lab name and lab value	Date performed	Lab name and lab value	Date performed

Any additional information pertinent to this request:

Complete this section for professionally administered medications (including buy-and-bill).

Drug name:		HCPCS code:
Start date:	End date:	Is this a request for reauthorizaton? ☐ Yes ☐ No
Treatment setting: ☐ Outpatient ☐ Home infusion ☐ In-office ☐ Other:		
Servicing prescriber/facility name:		☐ Same as prescribing clinician
Provider/facility address:		
Servicing provider NPI/Tax ID #:	Name of billing provider:	Billing provider NPI #:

Patient name:	Medicaid ID #:
Provider name:	Provider phone number:

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.

Prescriber's signature: _____ Date: _____

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