New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Systemic Immunomodulators Medication

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

Patient's Name

Medicaid Number

Date of Birth (MM/DD/YYYY) / /

Gender ☐ Male ☐ Female

Drug Name

Strength

Dosing Schedule

Length of Therapy

Number of Injections Needed

HCPC Code (for medical claims only)

SECTION II: CLINICAL HISTORY

1. **Patient's diagnosis for use of this medication** (please be complete and use a separate sheet if additional space is required):
2. **Previous failure, contraindication, or adverse reaction to methotrexate AND at least one DMARD (sulfasalazine, hydroxychloroquine, minocycline):** (For diagnosis of Rheumatoid Arthritis only) ☐ Yes ☐ No
3. **Previous failure, contraindication, or adverse reaction to IV cyclosporine AND azathioprine or mercaptopurine for three months AND diagnosis of fistula by colonic endoscopy:** (For diagnosis of Fistulizing Crohn's Disease only) ☐ Yes ☐ No
4. **Previous failure, contraindication, or adverse reaction to oral corticosteroid AND azathioprine or mercaptopurine for three months AND parenteral methotrexate for three months:** (For diagnosis of Crohn's disease) ☐ Yes ☐ No
5. **Previous failure, contraindication, or adverse reaction to oral/rectal aminosalicylate AND oral corticosteroid AND azathioprine or mercaptopurine for three months:** (For diagnosis of active ulcerative colitis) ☐ Yes ☐ No
6. **Previous failure, contraindication, or adverse reaction to topical psoriasis agents:** (For diagnosis of severe chronic plaque psoriasis only) ☐ Yes ☐ No
7. **Does the patient have a diagnosis of moderate to severe heart failure?** ☐ Yes ☐ No
8. **Is the patient pregnant?** (Female only) ☐ Yes ☐ No
9. **Is the patient currently on another systemic immunomodulator?** ☐ Yes ☐ No
   If yes, list medication:
10. **Is the patient HIV positive?** ☐ Yes ☐ No
11. **Is there any additional information that would help in the decision-making process?** ☐ Yes ☐ No

SECTION III: 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 ☐ Drug-to-Drug Interaction — **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:**

☐ 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:**

Fax to Magellan Rx Management if medications can be dispensed from a pharmacy.
Phone: 1-866-675-7755
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-271-8194

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Effective Date: 09/23/2015

Magellan Rx MANAGEMENT℠

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Patient's Name

Medicaid Number

SECTION IV: PRESCRIBER INFORMATION

Group Medicaid ID Number

Medicaid Provider ID Number

Name

NPI Number

Prescriber Phone Number -

Prescriber Fax 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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