



New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form
 Anti-Fungal Medication for Onychomycosis

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

				-					-				
--	--	--	--	---	--	--	--	--	---	--	--	--	--

GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SPECIALTY:

NPI NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PHONE NUMBER:

				-					-				
--	--	--	--	---	--	--	--	--	---	--	--	--	--

FAX NUMBER:

				-					-				
--	--	--	--	---	--	--	--	--	---	--	--	--	--

SECTION III: CLINICAL HISTORY

1. Patient's diagnosis: _____
2. List pertinent laboratory test(s) or procedure(s), if applicable (KOH, PAS, Culture, etc.):

PROCEDURE	DATE OF PROCEDURE	FINDINGS
_____	____ / ____ / _____	_____
_____	____ / ____ / _____	_____
_____	____ / ____ / _____	_____

3. Does the patient have immunosuppression, diabetes, or significant peripheral vascular compromise? Yes No

a. If Yes, please list which diagnosis: _____

4. Is the patient experiencing pain that limits normal activity? Yes No

Provide any additional information that would help in the decision-making process? *If additional space is needed, please use another page.*

(Form continued on next page.)



New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form
 Anti-Fungal Medication for Onychomycosis

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PATIENT FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

If you are requesting a non-preferred product, complete Section IV. If not, then proceed to Prescriber's Signature.

SECTION IV: 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 provide clinical information:

- 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:

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:** _____