



**New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form**

Restless Leg Syndrome Medication

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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SECTION III: 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
 - a. If yes, list date taken and reason for failure:

(Form continued on next page.)



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (Continued)

3. Has the patient tried and failed or does patient have a contraindication to levodopa/carbidopa, Yes No pramipexole, or ropinirole?

a. If yes, list medication failed, date taken, and reason for failure or list medication contraindicated with specific reasons for contraindication:

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

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:** _____