



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

Stromectol® (ivermectin)

DATE OF MEDICATION REQUEST:        /        /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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

MEDICAID ID NUMBER:

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

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:

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

PHONE NUMBER:

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

FAX NUMBER:

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## SECTION III: CLINICAL HISTORY

1.	Does the patient have a diagnosis of scabies?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	If Yes, please list treatment failures and provide dates or concurrent treatment:	
2.	Does the patient have a diagnosis of parasitic infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Provide 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: \_\_\_\_\_