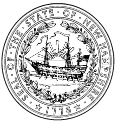

New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form

Atopic Dermatitis Medications

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. Please provide the diagnosis/condition this medication is being prescribed to treat:
2. What is the patient's age?
3. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? ☐ Yes ☐ No

   If *yes*, please describe treatment failure, contraindication, or intolerance and provide date:

4. Has the patient been treated with a topical immunomodulator in the past? ☐ Yes ☐ No

   If *yes*, please provide drug name and duration of therapy:

(Form continued on next page.)

Phone: 1-800-424-7901
Fax: 1-800-424-7984

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Review date: 02/24/2021

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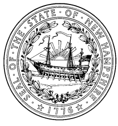

New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form

Atopic Dermatitis Medications

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(Continued)*

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

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. **Describe reaction:**
- ☐ Drug-to-drug interaction. **Describe reaction:**
- ☐ Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**
- ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**
- ☐ Age-specific indications. **Provide patient age and explain:**
- ☐ Unique clinical indication supported by FDA approval or peer-reviewed literature. **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:** ___________________

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