



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

Inhaled Insulin Medications

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. Please list recent FEV1 level and date taken: _____
2. Does patient have concurrent diagnosis of COPD, asthma, or emphysema? Yes No
3. Is the patient an active cigarette smoker? Yes No
 - a. If *no* to question 3, list date of last cigarette smoked: _____
4. Does the patient have a diagnosis of Type 1 diabetes? Yes No
 - a. If *yes* to question 4, has the patient had a history of treatment failure with fast acting SC insulin? Yes No
 - b. If *yes* to question 4, will the patient be on concurrent use of a long acting insulin? Yes No

(Form continues on the 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)

5. Does the patient have a diagnosis of type 2 diabetes? Yes No

a. If yes to question 5, please provide patient's HgA1C: _____

b. If yes to question 5, has the patient had a history of treatment failure with fast acting SC insulin? Yes No

c. If yes to question 5, list maximum doses of sulfonylureas, metformin, and TZDs: _____

6. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. Yes No

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:** _____