



# New Hampshire AIDS Drug Assistance Program

## Prior Authorization Drug Approval Form

New Drug Product Medication Request

DATE OF MEDICATION REQUEST:    /    /

### SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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

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:

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PHONE NUMBER:

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FAX NUMBER:

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### SECTION III: CLINICAL HISTORY

1. What is the rationale for this request for restricted medication?

Allergic reaction     Drug-to-drug interaction

Please describe the reaction:

2. Please provide information about any previous episodes of an unacceptable side effect or therapeutic failure.

Please provide clinical information:

(Form continued on next page.)



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**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**SECTION III: CLINICAL HISTORY (Continued)**

3. Please provide information about any clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug.

**Please provide clinical information:**

4. Please provide information about any age-specific indications.

**Please provide patient age and explain:**

5. Please provide information about any unique clinical indication supported by FDA approval or peer-reviewed literature.

**Please explain and provide a reference:**

6. Please provide information about any unacceptable clinical risk associated with therapeutic change.

**Please explain:**

7. 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:** \_\_\_\_\_