



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

Oral Isotretinoin 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 provide the diagnosis/condition this medication is being prescribed to treat: _____

2. Has the patient failed at least two conventional acne treatments? _____

Yes No

a. Please list treatment failures and dates:

3. Are patient and provider registered to the iPLEDGE® risk management program and are all requirements met, INCLUDING, if appropriate, a confirmed negative serum pregnancy test and a plan for contraception in place? _____

Yes No

(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)

4. Has patient used oral isotretinoin therapy in the past? Yes No

a. If yes, please provide medication names and dates:

5. 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:** _____