NEW HAMPSHIRE TUBERCULOSIS PHARMACY PROGRAM

PRIOR AUTHORIZATION REQUEST FORM

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

Date of Medication Request: _____ / _____ /_____

Member Information

LAST NAME: **FIRST NAME:**

SOUNDEX NUMBER: **DATE OF BIRTH:** **SEX:**

☐ Male ☐ Female

Prescriber Information

LAST NAME: **FIRST NAME:**

NPI NUMBER:

PHONE NUMBER: **FAX NUMBER:**

Medication Requested

DRUG NAME: **STRENGTH:**

DOSING INSTRUCTIONS: **LENGTH OF THERAPY:**

MEDICAL DIAGNOSIS:

Medical History

PLEASE LIST ANY ADDITIONAL CLINICAL INFORMATION:

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 Signature (Required) ***Date***

Fax completed forms to:

New Hampshire Tuberculosis Pharmacy Program

Phone: 1-800-424-7901

Fax: 1-800-424-7984

https://nhadap.magellanmedicaid.com

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