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New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form
Brand Name Multiple Source Prescription 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. Has the patient experienced a therapeutic failure (inadequate response) to an "A" rated generic? ☐ Yes ☐ No
   If so, please describe:
2. Has the patient experienced an adverse reaction to an "A" rated generic? ☐ Yes ☐ No
   If so, please describe:
3. In the prescriber's opinion, does transition to another generic in the same therapeutic category represent an unacceptable risk to the patient? ☐ Yes ☐ No
   If so, please describe:
4. Does the patient have an allergy to one of the components of the generic (i.e. dye)? ☐ Yes ☐ No
   If so, please describe:

(Form continued on next page.)

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

5. Has a MEDWATCH form been submitted to the FDA? ☐ Yes ☐ No

NOTE: Do not submit form to Prime Therapeutics State Government Solutions LLC. Information regarding the form can be found at:
http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm

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

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**: _____