



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

CNS Stimulant and ADHD/ADD Medication

DATE OF MEDICATION REQUEST:    /    /

## SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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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 patient's diagnosis for use of this medication? \_\_\_\_\_
2. Does the patient have swallowing issues? (*For Daytrana patch<sup>®</sup>, ProCentra<sup>®</sup>, and Xelstrym<sup>®</sup> only*).  Yes  No
3. Does the patient have a history of low blood pressure or low heart rate? (*For Kapvay<sup>®</sup> and Intuniv<sup>®</sup> only*).  Yes  No
4. Is there any additional information that would help in the decision-making process? *If additional space is needed, please use another page.*  Yes  No

*If you are requesting a non-preferred product, proceed to Section IV.*

## SECTION IV: NON-PREFERRED DRUG APPROVAL CRITERIA

Chapter 188 of the Laws of 2004 requires that Medicaid only cover non-preferred drugs upon a finding of medical necessity by the prescribing physician. Chapter 188 requires that you base your determination of medical necessity on the following criteria

- Allergic reaction. Describe reaction: \_\_\_\_\_
- Drug-to-drug interaction. Describe reaction: \_\_\_\_\_
- Previous episode of unacceptable side effects or therapeutic failure. Provide clinical information: \_\_\_\_\_
- Age specific indications. Provide patient age and explain: \_\_\_\_\_
- Unique clinical indication supported by FDA approval or peer reviewed literature. Explain and provide a reference: \_\_\_\_\_
- Unacceptable clinical risk associated with therapeutic change. Please explain: \_\_\_\_\_

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: \_\_\_\_\_