



New Hampshire AIDS Assistance Program

Prior Authorization/Non-Preferred Drug Approval Form

Pulmonary Arterial Hypertension – Phosphodiesterase Type-5 (PDE-5) Inhibitor Only

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:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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

PHONE NUMBER:

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

FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. For what condition is this medication being prescribed? _____
2. Is the prescriber a cardiologist or pulmonologist experienced in the diagnosis and treatment of pulmonary hypertension, OR has one of these specialists been consulted in this case? Yes No
3. Will the patient be on concurrent organic nitrates, guanylate cyclase stimulators, or other PAH medications? Yes No
4. Is the request for sildenafil? Yes No
 - a. If Yes, will there be concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/tenofovir/emtricitabine? Yes No
5. Is the patient unable to take oral tablets? Yes No
 - a. If Yes, please explain: _____

(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)

Provide 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:** _____