Reset Form Print Form

# New Hampshire AIDS Drug Assistance Program
# Prior Authorization/Non-Preferred Drug Approval Form

Topical Retinoids

**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. Patient's diagnosis for use of this medication (please be complete and use a separate sheet if additional space is required):

   _____

2. Is the medication being used to treat any of the following: ☐ Yes ☐ No

   - Photoaging
   - Wrinkling
   - Hyperpigmentation
   - Sun damage
   - Melasma

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

*(Form continues on next page.)*

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Topical Retinoids

| PATIENT LAST NAME: | | | | | | | | | | | | PATIENT FIRST NAME: | | | | | | | | | | | |
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## 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 an unacceptable side effect or therapeutic failure. **Provide clinical information:**

_____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **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**: _____

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

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