



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

Asthma/Allergy Immunomodulator

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. For what condition is this medication being prescribed? _____
2. Is a pulmonologist, allergist, or immunologist prescribing this medication, or has one of these specialists been consulted in this case? Yes No

For an asthma diagnosis request, complete questions 3–6.

3. Is the patient symptomatic despite taking medium-to-high dose of inhaled corticosteroids or oral steroids in combination with either a long-acting beta₂ agonist, a leukotriene modifier, or theophylline? Yes No

If **yes**, please indicate which medication(s) patient is currently taking:

- LABA: _____
- Leukotriene receptor agonist: _____
- Theophylline

(Form continued on next page.)



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

Asthma/Allergy Immunomodulator

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

SECTION III: CLINICAL HISTORY (CONTINUED)

- 4. Has the patient's allergy been confirmed by skin testing or *in vitro* activity to the allergen? Yes No
- 5. Is the patient poorly compliant on the current asthma treatment plan? Yes No
- 6. Is the patient an active smoker? Yes No

For a nasal polyps diagnosis request, complete question 7.

- 7. Has the patient had an inadequate response to nasal corticosteroids? Yes No
- If **yes**, please list the nasal corticosteroids below with the dates of therapy.

For a hypereosinophilic syndrome diagnosis request, complete questions 8–9.

- 8. Has the hypereosinophilic syndrome lasted 6 months or longer? Yes No
- 9. Have secondary causes been ruled out? Yes No

For a chronic spontaneous urticaria diagnosis request, complete question 10.

- 10. Has the patient had an inadequate response to a first- or second-generation antihistamine? Yes No
- If **yes**, please list the antihistamines below with the dates of therapy.

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:** _____