Reset Form Print Form

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

Convenience Kits (Rx)

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. Has the patient had a trial of the active ingredient or ingredients in the kit? ☐ Yes ☐ No
3. Is the active ingredient as a separate prescription on short supply? ☐ Yes ☐ No

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

(Form continued on next page.)

Prime THERAPEUTICS™

New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form
Convenience Kits (Rx)

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

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

Prime THERAPEUTICS™