



New Hampshire AIDS Drug Assistance Program

Prior Authorization

Medical Necessity Rationale Required

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. What is the justification for this formulation or strength? **(Check all that apply.)** Yes No

- Contraindication to other available formulations or strengths
- Co-morbidity that requires this formulation or strength
- Unique patient circumstance that requires this formulation or strength

Provide clinical documentation to support selection.

2. Is there an unacceptable clinical risk associated with a therapeutic change? Yes No

If yes, provide an explanation with documentation:
