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

**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

**Atopic Dermatitis– Other indications skip to *question 8*.**

1. What is the patient's diagnosis or condition that this medication is being prescribed to treat?

2. What is the patient's age?
3. Is a dermatologist, immunologist, or allergist prescribing this medication, **or** has one been consulted in this case? ☐ Yes ☐ No
4. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? ☐ Yes ☐ No
   If **yes**, describe treatment failure, contraindication, or intolerance and provide date:



Effective Date: 12/04/2024

**New Hampshire Medicaid Fee-for-Service (FFS) Program**
**Prior Authorization/Non-Preferred Drug Approval Form**
Skin Disorders

**PATIENT LAST NAME:** | | | | | | | | | | | | |

**PATIENT FIRST NAME:** | | | | | | | | | | | | |

5. Has the patient been treated with a topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus) in the past? ☐ Yes ☐ No

   If **yes**, provide drug name and duration of therapy:

6. **Opzelura® and Zoryve® only:** Has the patient been treated with a topical phosphodiesterase-4 inhibitor (e.g., crisaborole) in the past? ☐ Yes ☐ No

   If **yes**, provide drug name and duration of therapy:

7. **Systemic treatment only**: Will the patient also receive therapy with any other monoclonal antibody biologic (e.g., tezepelumab, omalizumab, mepolizumab, reslizumab, dupilumab)? ☐ Yes ☐ No

**Other Indications (8-11)**

8. Does the patient have a diagnosis of nonsegmental vitiligo? ☐ Yes ☐ No
9. What is the patient's age? _____
10. Is the prescriber a dermatologist? ☐ Yes ☐ No
11. Provide any additional information that would help in the decision-making process.
    If additional space is needed, please use a separate sheet.

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**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

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