

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

Systemic Immunomodulators Medication

DATE OF MEDICATION REQUEST: /	/
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SECTION I: PATIENT INFORMATION AND MEDICATION F	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:		<u>                                     </u>	1 1										
			_											
SECTION III: CLINICAL HISTORY														
<ol> <li>Patient's diagnosis for use of this medication (please required):</li> </ol>	be complete and use	e a separat	te sheet if	addition	nal spac	e is								
Please respond to the following questions based on the	diagnosis that the r	medication	n is being	requeste	ed for:									
2. <b>Rheumatoid Arthritis:</b> Did the patient have a previou adverse reaction to methotrexate <b>and</b> at least one DN hydroxychloroquine, minocycline)?			o, or		Yes [	No								
<ol> <li>Moderately to Severely Active Crohn's Disease: Did to contraindication to, or adverse reaction to an oral contraindication.</li> </ol>		revious fai	lure of,		Yes [	No								
(Form continued on the next page.)														

Fax to Prime Therapeutics Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.

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

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Review Date: 12/04/2024





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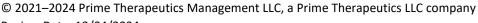
Systemic Immunomodulators Medication

**DATE OF MEDICATION REQUEST:** 

PATIENT LAST NAME:													PATIENT FIRST NAME:												
SE	SECTION III: CLINICAL HISTORY (Continued)																								
4.	. Moderately to Severely Active Ulcerative Colitis: Did the patient have a previous failure of, contraindication to, or adverse reaction to an oral or rectal aminosalicylate and oral corticosteroid and azathioprine or mercaptopurine for three months?															Y	'es	☐ No							
5.	Severe Chronic Plaque Psoriasis: Did the patient have a previous failure of, contraindication to or adverse reaction to a topical psoriasis agent?														0,		'es	☐ No							
6.	5. <b>Ankylosing Spondylitis:</b> Did the patient have a previous failure, contraindication to, or adverse reaction to an nonsteroidal anti-inflammatory drugs (NSAID)?													e	Y	'es	☐ No								
7.	7. <b>Psoriatic Arthritis or Juvenile Idiopathic Arthritis:</b> Did the patient have a previous failure of, contraindication to, or adverse reaction to methotrexate?													Y	'es	☐ No									
8.	Does the patient have a diagnosis of moderate to severe heart failure?													Y	'es	☐ No									
9.	Fo	or Co	oser	ntyx	® on	l <b>y:</b> Do	es th	e pa	tient	have	e a di	agno	sis o	of irri	table	bow	vel sy	yndr	ome	?			Y	'es	☐ No
10.	10. Is the patient pregnant?													Y	'es	☐ No									
11.	ls	the	pat	ient	curr	ently	on a	noth	er sys	stem	ic im	mun	omo	dula	tor?								Y	'es	☐ No
	If <b>yes</b> , list medication:																								
Please provide any additional information that would help in the decision-making process. <b>If additional space is needed, please use a separate sheet.</b>																									
(Fo	(Form continued on the next page.)																								

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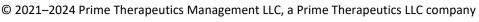
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		D	ATE	OF I	MEDI	CATI	ION F	REQU	JEST:				/_												
PATIENT LAST NAME:													PATIENT FIRST NAME:												
	1			•										•											
SECT	ΓΙΟΝ	IV: N	ON-	PREI	FERR	ED D	RUG	APP	ROV	AL C	RITE	RIA	1												
Chapter 188 of the Laws 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 Drug-to-drug interaction Please describe reaction:																									
F	Previo	ous ep	oiso	de of	f an u	nacc	epta	ble s	ide e	effect	t or t	hei	rapeu	itic f	ailure	e. Ple	ease	descr	ibe re	eactic	n:				
		al con						-	, or ι	ıniqu	ie pa	tie	nt cir	cum	stanc	e as	а со	ntrai	ndicat	tion t	o a pi	 referi	red d	rug.	
	\ge-s	pecifi	c ind	dicat	ions.	Plea	se pr	ovid	e pat	ient	age	and	d exp	lain:											
	-	ue clin ence:	iical	indi	catio	n sup	port	ed by	y FD <i>F</i>	A app	orova	al o	r pee	r-rev	viewe	ed lit	eratı	ure. P	lease	expla	ain ar	nd pro	ovide	e a	
	Jnac	ceptal	ble d	clinic	al ris	k ass	ociat	ed w	ith t	hera	peut	ic c	chang	e. Pl	ease	exp	ain:								
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.																									
PRES	SCRII	BER'S	SIG	NAT	URE:							,						D	ATE:						
•		able) d prov		-					be <sub>l</sub>	prov	ided		_												

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