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

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):

Please respond to the following questions based on the diagnosis that the medication is being requested for:

2. **Rheumatoid Arthritis:** Did the patient have a previous failure of, contraindication to, or adverse reaction to methotrexate **and** at least one DMARD (e.g., sulfasalazine, hydroxychloroquine, minocycline)? ☐ Yes ☐ No
3. **Moderately to Severely Active Crohn's Disease:** Did the patient have a previous failure of, contraindication to, or adverse reaction to an oral corticosteroid? ☐ 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

Review Date: 12/04/2024

Prime THERAPEUTICS™

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PATIENT LAST NAME: **PATIENT FIRST NAME:**

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? ☐ Yes ☐ No
5. **Severe Chronic Plaque Psoriasis:** Did the patient have a previous failure of, contraindication to, or adverse reaction to a topical psoriasis agent? ☐ Yes ☐ No
6. **Ankylosing Spondylitis:** Did the patient have a previous failure, contraindication to, or adverse reaction to an nonsteroidal anti-inflammatory drugs (NSAID)? ☐ Yes ☐ No
7. **Psoriatic Arthritis or Juvenile Idiopathic Arthritis:** Did the patient have a previous failure of, contraindication to, or adverse reaction to methotrexate? ☐ Yes ☐ No
8. Does the patient have a diagnosis of moderate to severe heart failure? ☐ Yes ☐ No
9. **For Cosentyx® only:** Does the patient have a diagnosis of irritable bowel syndrome? ☐ Yes ☐ No
10. Is the patient pregnant? ☐ Yes ☐ No
11. Is the patient currently on another systemic immunomodulator? ☐ Yes ☐ No

If **yes**, list medication: _____

Please provide any additional information that would help in the decision-making process. **If additional space is needed, please use a separate sheet.**

(Form continued on the next page.)

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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 ☐ Drug-to-drug interaction Please describe reaction:

_____

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please describe reaction:

_____

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information:

_____

☐ Age-specific indications. Please provide patient age and explain**:**

_____

☐ Unique clinical indication supported by FDA approval or peer-reviewed literature. Please 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**: _____

(If applicable) facility where infusion is to be provided: _____

Medicaid provider number of facility: _____

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