



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:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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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

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:

Phone: 1-603-271-9384

Fax: 1-603-314-8101





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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (Continued)

- 4. **Moderately to Severely Active Ulcerative Colitis:** Did the patient have a previous failure of, Yes No
contraindication to, or adverse reaction to an oral or rectal aminosalicylate **and** oral
corticosteroid **and** azathioprine or mercaptopurine for three months?
- 5. **Severe Chronic Plaque Psoriasis:** Did the patient have a previous failure of, Yes No
or adverse reaction to a topical psoriasis agent?
- 6. **Ankylosing Spondylitis:** Did the patient have a previous failure, Yes No
contraindication to, or adverse
reaction to an nonsteroidal anti-inflammatory drugs (NSAID)?
- 7. **Psoriatic Arthritis or Juvenile Idiopathic Arthritis:** Did the patient have a previous failure of, Yes No
contraindication to, or adverse reaction to methotrexate?
- 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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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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