



NEW HAMPSHIRE TUBERCULOSIS PHARMACY PROGRAM

PRIOR AUTHORIZATION REQUEST FORM

Fax: 1-800-424-7984

Phone: 1-800-424-7901

Date of Medication Request: _____

Member Information

LAST NAME:

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FIRST NAME:

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SOUNDEX NUMBER:

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DATE OF BIRTH:

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SEX:

Male Female

Prescriber Information

LAST NAME:

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FIRST NAME:

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NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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Medication Requested

DRUG NAME: _____

STRENGTH: _____

DOSING INSTRUCTIONS: _____

LENGTH OF THERAPY: _____

MEDICAL DIAGNOSIS: _____

Medical History

PLEASE LIST ANY ADDITIONAL CLINICAL INFORMATION:

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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 Signature (Required)

Date

Fax completed forms to:

New Hampshire Tuberculosis Pharmacy Program

Phone: 1-800-424-7901

Fax: 1-800-424-7984

<https://nhadap.magellanmedicaid.com>

