



New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Brand Name Multiple Source Prescription Medications

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. Has the patient experienced a therapeutic failure (inadequate response) to an "A" rated generic? ☐ Yes ☐ No

If so, please describe: _____

2. Has the patient experienced an adverse reaction to an "A" rated generic? ☐ Yes ☐ No

If so, please describe: _____

3. In the prescriber's opinion, does transition to another generic in the same therapeutic category represent an unacceptable risk to the patient? ☐ Yes ☐ No

If so, please describe: _____

4. Does the patient have an allergy to one of the components of the generic (i.e. dye)? ☐ Yes ☐ No

If so, please describe: _____

(Form continued on next page.)



New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Brand Name Multiple Source Prescription Medications

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PATIENT FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

SECTION III: CLINICAL HISTORY (*Continued*)

5. Has a MEDWATCH form been submitted to the FDA?

☐ Yes ☐ No

NOTE: Do not submit form to Magellan Medicaid Administration. Information regarding the form can be found at:
<http://www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm>

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

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:** _____