



**New Hampshire Medicaid Fee-for-Service Program  
Prior Authorization Drug Approval Form**

Oral Isotretinoin 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. Please provide the diagnosis/condition this medication is being prescribed to treat: \_\_\_\_\_

2. Has the patient failed at least two conventional acne treatments? \_\_\_\_\_

☐ Yes   ☐ No

a. Please list treatment failures and dates: \_\_\_\_\_

3. Are patient and provider registered to the iPLEDGE® risk management program and are all requirements met, INCLUDING, if appropriate, a confirmed negative serum pregnancy test and a plan for contraception in place? \_\_\_\_\_

☐ Yes   ☐ No

*(Form continued on next page.)*



**New Hampshire Medicaid Fee-for-Service Program  
Prior Authorization Drug Approval Form**

Oral Isotretinoin Medications

**DATE OF MEDICATION REQUEST:**     /     /

**PATIENT LAST NAME:**

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

**PATIENT FIRST NAME:**

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

**SECTION III: CLINICAL HISTORY (*Continued*)**

4. Has patient used oral isotretinoin therapy in the past?

☐ Yes    ☐ No

a. If yes, please provide medication names and dates:

5. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

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:** \_\_\_\_\_

**Phone:** 1-866-675-7755

**Fax:** 1-888-603-7696

**MagellanRx**  
MANAGEMENT<sup>SM</sup>