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New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Pulmonary Arterial Hypertension – Phosphodiesterase Type-5 (PDE-5) Inhibitor Only

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. For what condition is this medication being prescribed? _____
2. Is the prescriber a cardiologist or pulmonologist experienced in the diagnosis and treatment of pulmonary hypertension, OR has one of these specialists been consulted in this case? ☐ Yes ☐ No
3. Will the patient be on concurrent organic nitrates, guanylate cyclase stimulators, or other PAH medications? ☐ Yes ☐ No
4. Is the request for sildenafil? ☐ Yes ☐ No
   a. If *Yes*, will there be concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/tenofovir/emtricitabine? ☐ Yes ☐ No
5. Is the patient unable to take oral tablets? ☐ Yes ☐ No
   a. If *Yes*, please explain: _____

(Form continued on next page.)

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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(CONTINUED)*

Provide any additional information that would help in the decision-making process. *If additional space is needed, please use another page.*

If you are requesting a non-preferred product, complete Section IV. If not, then proceed to Prescriber's Signature.

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 provide clinical information:

_____

☐ 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**: _____