



New Hampshire Medicaid Fee-for-Service (FFS) Program

Prior Authorization/Non-Preferred Drug Approval Form

Skin Disorders

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

Atopic Dermatitis Topical Therapy (1–5) – Other indications skip to *question 12*.

1. Provide the diagnosis/condition this medication is being prescribed to treat:

2. What is the patient's age? _____

3. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? Yes No

If yes, describe treatment failure, contraindication, or intolerance and provide date:

4. Has the patient been treated with a topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus) in the past? Yes No

If yes, provide drug name and duration of therapy:



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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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5. Opzelura® only: Has the patient been treated with a topical phosphodiesterase-4 inhibitor (e.g., crisaborole) in the past?
 If yes, provide drug name and duration of therapy:

Atopic Dermatitis Systemic Therapy (6–11)

6. Is a dermatologist, immunologist, or allergist prescribing this medication, OR has one been consulted in this case? Yes No
7. What is the patient's age? _____
8. Has there been a failure, contraindication, or intolerance to topical corticosteroid therapy? Yes No
 a. If yes, describe treatment failure, contraindication, or intolerance and provide date:
9. Has the patient been treated with a topical calcineurin inhibitor (e.g., pimecrolimus or tacrolimus) in the past? Yes No
 a. If yes, provide drug name and duration of therapy:
10. Has the patient been treated with a topical phosphodiesterase-4 inhibitor (e.g., crisaborole) in the past? Yes No
11. Will the patient also receive therapy with any other monoclonal antibody biologic (e.g., tezepelumab, omalizumab, mepolizumab, reslizumab, dupilumab)? Yes No

Other Indications (12–14)

12. Does the patient have a diagnosis of nonsegmental vitiligo? Yes No
13. What is the patient's age? _____
14. Is the prescriber a dermatologist? Yes No
15. Provide any additional information that would help in the decision-making process.
 If additional space is needed, please use a separate sheet.



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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. **Describe reaction:**

Drug-to-drug interaction. **Describe reaction:**

Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**

Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**

Age-specific indications. **Provide patient age and explain:**

Unique clinical indication supported by FDA approval or peer-reviewed literature. **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:** _____