New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Systemic Immunomodulators Medication

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. Patient's diagnosis for use of this medication (please be complete and use a separate sheet if additional space is required):

Please respond to the following questions based on the diagnosis that medication is being requested for:

2. **Rheumatoid Arthritis:** Did patient have a previous failure of, contraindication to, or adverse reaction to methotrexate AND at least one DMARD (sulfasalazine, hydroxychloroquine, minocycline)? ☐ Yes ☐ No
3. **Moderately to Severely Active Crohn's Disease:** Did patient have a previous failure of, contraindication to, or adverse reaction to oral corticosteroid? ☐ Yes ☐ No

(Form continued on the next page.)

Fax to Magellan Rx Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.
Phone: 1-866-675-7755
Fax: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:
Phone: 1-603-271-9384
Fax: 1-603-271-8194

Effective Date: 02/24/2021

Magellan Rx MANAGEMENT

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PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

4. **Moderately to Severely Active Ulcerative Colitis:** Did patient have a previous failure of, contraindication to, or adverse reaction to oral/rectal aminosalicylate AND oral corticosteroid AND azathioprine or mercaptopurine for three months? ☐ Yes ☐ No
5. **Severe Chronic Plaque Psoriasis:** Did patient have a previous failure of, contraindication to, or adverse reaction to topical psoriasis agents? ☐ Yes ☐ No
6. **Ankylosing Spondylitis:** Did patient have a previous failure, contraindication, or adverse reaction to NSAIDS? ☐ Yes ☐ No
7. **Psoriatic Arthritis or Juvenile Idiopathic Arthritis:** Did patient have a previous failure of, contraindication to, or adverse reaction to methotrexate? ☐ Yes ☐ No
8. Does the patient have a diagnosis of moderate to severe heart failure? ☐ Yes ☐ No
9. Does the patient have a diagnosis of irritable bowel syndrome? (For Cosentyx® only) ☐ Yes ☐ No
10. Is the patient pregnant? ☐ Yes ☐ No
11. Is the patient currently on another systemic immunomodulator? ☐ Yes ☐ No
    a. If *yes*, list medication: _____
12. Is the patient HIV positive? ☐ Yes ☐ No
13. Is there any additional information that would help in the decision-making process? ☐ Yes ☐ No

_____

(Form continued on the next page.)

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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 ☐ Drug-to-Drug Interaction Please describe reaction:

_____

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please describe reaction:

_____

☐ 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**: _____

If applicable: Facility where infusion to be provided: _____
Medicaid Provider Number of Facility: _____

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