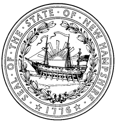

New Hampshire AIDS Drug Assistance Program (ADAP)
Prior Authorization Drug Approval Form

Preferred Drug List

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

NH ADAP SOUNDEX ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Note that the following drugs classes require separate prior authorization: Anti-Obesity agents, COX II, Onychomycosis agents, Proton Pump Inhibitors, Rheumatologic agents, and CNS Stimulants. Please use class specific form found on the DHHS website at: http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.html

Medication Diagnosis

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: MEDICAL HISTORY

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**: ______

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