



New Hampshire AIDS Drug Assistance Program
Prior Authorization/Non-Preferred Drug Approval Form
 Movement Disorders

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- Does the patient have a diagnosis of Huntington's Chorea? Yes No
- Does the patient have a diagnosis of Tardive Dyskinesia? Yes No
- Does the patient have a diagnosis of Tourette's Syndrome? Yes No
- Is the patient currently receiving tetrabenazine, deutetabenazine, reserpine, valbenazine, or an MAOI? Yes No
- Is the patient pregnant? Yes No
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

For Xenazine® Only: Proceed to Section IV.

(Form continues on next page.)



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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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:** _____

