



**New Hampshire AIDS Drug Assistance 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 11*.

1. What is the patient’s diagnosis or condition that 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:



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

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

5. **Opzelura® only:** Has the patient been treated with a topical phosphodiesterase-4 inhibitor (e.g., crisaborole) in the past? Yes No

If **yes**, provide drug name and duration of therapy:

Atopic Dermatitis Systemic Therapy (6–10)

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

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) or a topical phosphodiesterase-4 inhibitor (e.g., crisaborole) in the past? Yes No

If **yes**, provide drug name and duration of therapy:

10. Will the patient also receive therapy with any other monoclonal antibody biologic (e.g., tezepelumab, omalizumab, mepolizumab, reslizumab, dupilumab)? Yes No

Other Indications (11–14)

11. Does the patient have a diagnosis of nonsegmental vitiligo? Yes No

12. What is the patient's age? _____

13. Is the prescriber a dermatologist? Yes No

14. Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.



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

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

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:** _____