



SYSTEMIC IMMUNOMODULATORS MEDICATIONS

New Hampshire Medicaid Prior Authorization Request Form

Fax to Magellan if medication is to be dispensed from a pharmacy

Magellan: Fax: 1-888-603-7696 Phone: 1-866-675-7755

Fax to Schaller Anderson if medication is dispensed/administered by a physician in the office or outpatient setting:

Schaller Anderson: Fax: 1-866-499-9334 Phone: 1-866-499-9335



Date of Medication Request: ____/____/____

Section I: Patient Information and Medication Requested

Name (Last, First): _____ NH Medicaid Number: _____

Date of Birth: ____/____/____ Gender: Male Female

Drug Name/Strength: _____ Dosing Schedule: _____

Number of injections required/requested: _____ Length of Therapy: From __/__/__ to __/__/__

Section II: Clinical History

- Patient's diagnosis for use of this medication: _____
- Previous failure, contraindication, or adverse reaction to methotrexate: Yes No
- Prior or current use of a DMARD (sulfasalazine, hydroxychloroquine, azathioprine, D-penicillamine, gold salts, or cyclosporine): Yes No
- Previous failure, contraindication, or adverse reaction to oral corticosteroid: (For diagnosis of Crohn's disease and Ulcerative Colitis only) Yes No
- Previous failure, contraindication, or adverse reaction to topical psoriasis agents: (For diagnosis of severe chronic plaque psoriasis only) Yes No
- Does the patient have a diagnosis of moderate to severe heart failure: Yes No
- Is the patient pregnant: (Female only) Yes No
- Is the patient currently on another systemic immunomodulator: List med. if Yes _____ Yes No
- Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

Section III: 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 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: _____

Section IV: Prescriber Information

Name: _____ Medicaid Provider ID # _____
NPI Number: _____
Phone Number: (____) _____ - _____ Fax Number: (____) _____ - _____

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.

Signature of Prescribing Provider

IF APPLICABLE: Facility where infusion is to be provided _____