



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

DATE OF MEDICATION REQUEST:     /     /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

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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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**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 the medication is being requested for:**

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

*(Form continued on the next page.)*

Fax to Prime Therapeutics Management LLC 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: 1-603-314-8101



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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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**SECTION III: CLINICAL HISTORY (Continued)**

4. **Moderately to Severely Active Ulcerative Colitis:** Did the patient have a previous failure of, ☐ Yes ☐ No  
contraindication to, or adverse reaction to an oral or rectal aminosalicylate **and** oral  
corticosteroid **and** azathioprine or mercaptopurine for three months?
5. **Severe Chronic Plaque Psoriasis:** Did the patient have a previous failure of, contraindication to, ☐ Yes ☐ No  
or adverse reaction to a topical psoriasis agent?
6. **Ankylosing Spondylitis:** Did the patient have a previous failure, contraindication to, or adverse ☐ Yes ☐ No  
reaction to a nonsteroidal anti-inflammatory drugs (NSAID)?
7. **Psoriatic Arthritis or Juvenile Idiopathic Arthritis:** Did the patient have a previous failure of, ☐ Yes ☐ No  
contraindication to, or adverse reaction to methotrexate?
8. Does the patient have a diagnosis of moderate to severe heart failure? ☐ Yes ☐ No
9. **For Cosentyx® only:** Does the patient have a diagnosis of irritable bowel syndrome? ☐ Yes ☐ No
10. Is the patient pregnant? ☐ Yes ☐ No
11. Is the patient currently on another systemic immunomodulator? ☐ Yes ☐ No

If **yes**, list medication: \_\_\_\_\_

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

*(Form continued on the next page.)*

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**PATIENT LAST 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    ☐ 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 is to be provided:** \_\_\_\_\_

**Medicaid provider number of facility:** \_\_\_\_\_

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