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Drug Name			<u> </u>											Strer	ngth:						
Dosing Dire	ctions	:												Leng	th of	The	rapy:				
SECTION II:	PRES	CRIBE	RINF	ORN	1ATIC	N															
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SECTION III	: CLIN	ICAL	HISTC	DRY																	
1. Patient's required		nosis f	for us	e of t	his m	edica	ition	(plea	ase b	e con	nplet	e anc	l use	a sep	oarat	e she	eet if	addi [.]	tiona	l spac	ce is
Please resp	ond to	the	follov	ving o	quest	ions l	based	d on '	the o	diagn	osis t	hat t	he m	edic	ation	is be	eing I	equ	ested	l for:	
2. Rheuma adverse hydroxy	reacti	on to	meth	otre	xate a										on tc), or			Y	es [] No
3. Modera contrain	tely to	Seve	erely	Activ	e Cro					-			a pro	eviou	ıs fail	ure c	of,		Y	es [] No
(Form conti	nued c	on the	next	page	?.)																
Fax to Prime will be dispe by the patien Phone: 1-866 Fax: 1-888-66	nsed by it or ca 5-675-7	/ a pha regive 755	irmacy	and v					out Pho	to DH patien one: 1- : 1-603	t sett i 603-2	i ng: 71-938		is disp	enseo	d/adn	niniste	ered b	y the	office	or

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New Hampshire Medicaid Fee-for-Service Program

Prior Authorization/Non-Preferred Drug Approval Form

Systemic Immunomodulators Medication

DATE OF MEDICATION REQUEST: /

PA	TIENT LAST NAME:	PATIENT FIRST NAME:												
SE	CTION III: CLINICAL HISTORY (Continued)													
4.	Moderately to Severely Active Ulcerative Colitis: Dic contraindication to, or adverse reaction to an oral or corticosteroid and azathioprine or mercaptopurine for	rectal a	min	osalio	cylate				of,	[] Yes	No No		
5.	. Severe Chronic Plaque Psoriasis: Did the patient have a previous failure of, contraindication to, or adverse reaction to a topical psoriasis agent?											🗌 No		
6.	Ankylosing Spondylitis: Did the patient have a previous reaction to an nonsteroidal anti-inflammatory drugs			ontra	aindi	catio	n to,	or ac	lverse	e [Yes	🗌 No		
7.	Psoriatic Arthritis or Juvenile Idiopathic Arthritis: Did the patient have a previous failure of, contraindication to, or adverse reaction to methotrexate?										Yes	🗌 No		
8.	Does the patient have a diagnosis of moderate to sev	vere hea	art fa	ilure	?						Yes	🗌 No		
9.	For Cosentyx [®] only: Does the patient have a diagnost	is of irri	itable	e bov	vel sy	ndrc	me?				Yes	🗌 No		
10	Is the patient pregnant?										Yes	🗌 No		
11	Is the patient currently on another systemic immuno	modula	itor?								Yes	🗌 No		
	If ves , 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.)

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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Age-s	pecific ii	ndicat	ions.	Plea	ise pi	rovid	e pat	tient	age	and	ехр	lain:										
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Review Date: 06/05/2025

