





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

DATE OF MEDICATION REQUEST:    /    /

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, contraindication to, or adverse reaction to an oral/rectal aminosalicylate AND oral corticosteroid AND azathioprine or mercaptopurine for three months?  Yes  No
- 5. **Severe Chronic Plaque Psoriasis:** Did the patient have a previous failure of, contraindication to, or adverse reaction to a topical psoriasis agent?  Yes  No
- 6. **Ankylosing Spondylitis:** Did the patient have a previous failure, contraindication to, or adverse reaction to an NSAID?  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 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
  - a. 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.)*

Fax to Magellan Rx Management 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: 1-603-271-8194



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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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