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New Hampshire Medicaid Fee-for-Service (FFS) Program
Prior Authorization/Non-Preferred Drug Approval Form
Anti-Fungal Medication for Onychomycosis

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

1. Patient's diagnosis: _____
2. List pertinent laboratory test(s) or procedure(s), if applicable (KOH, PAS, Culture, etc.):

PROCEDURE	DATE OF PROCEDURE	FINDINGS
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____
_____	_____ / _____ / _____	_____

3. Does the patient have immunosuppression, diabetes, or significant peripheral vascular compromise? ☐ Yes ☐ No
   a. If *Yes*, please list which diagnosis: _____
4. Is the patient experiencing pain that limits normal activity? ☐ Yes ☐ No

Provide any additional information that would help in the decision-making process? *If additional space is needed, please use another page.*

(Form continued on next page.)

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

Review Date: 10/28/2022

Magellan Rx MANAGEMENT

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Prior Authorization/Non-Preferred Drug Approval Form
Anti-Fungal Medication for Onychomycosis

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

If you are requesting a non-preferred product, complete Section IV. If not, then proceed to Prescriber's Signature.

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 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:

_____

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**: _____

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