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New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Benign Prostatic Hyperplasia (BPH) Medications

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 for use of this medication: _____
2. Has the patient failed a trial of an alpha blocker and an androgen hormone inhibitor? ☐ Yes ☐ No
   a. Please list medications and dates of trials: _____
3. Will the patient be on concurrent nitrate, alpha blocker, Revatio, Adcirca or guanylate cyclase stimulator? ☐ Yes ☐ No
4. Is there any additional information that would help in the decision-making process? **If additional space is needed, please use another page.**

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**: _____

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

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Magellan Rx MANAGEMENT