Reset Form Print Form

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

Bowel Disorder 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. Is the medication being prescribed for the treatment of chronic constipation? ☐ Yes ☐ No
   *If **yes**, answer questions 5–9.*
2. Is the medication being prescribed for the treatment of irritable bowel syndrome? ☐ Yes ☐ No
   *If **yes**, go to question 7.*
3. Is the medication being prescribed for opioid-induced constipation? *If **yes**, go to question 7.* ☐ Yes ☐ No
   *If **no**, list patient diagnosis for use of this medication:* _____
4. Is the patient averaging less than three spontaneous bowel movements per week? ☐ Yes ☐ No
5. Has the patient been experiencing constipation symptoms for at least three months? ☐ Yes ☐ No
6. Has the patient failed a trial or past therapy with at least 60 mL/day of lactulose? ☐ Yes ☐ No
   (**Describe in question 12 field**).
7. Has the patient failed a trial or past therapy with polyethylene glycol (MiraLAX®)? ☐ Yes ☐ No
   (**Describe in question 12 field**).
8. Does the patient have a history of mechanical gastrointestinal obstruction? ☐ Yes ☐ No
9. Is the patient 18 years of age or older? ☐ Yes ☐ No

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PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(continued)*

10. Is the patient pregnant? ☐ Yes ☐ No

11. Please describe treatment failure(s) and provide dates:

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

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. **Describe reaction:**

☐ Drug-to-drug interaction. **Describe reaction:**

☐ Previous episode of an unacceptable side effect or therapeutic failure. **Provide clinical information:**

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. **Provide clinical information:**

☐ Age-specific indications. **Provide patient age and explain:**

☐ Unique clinical indication supported by FDA approval or peer-reviewed literature. **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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