



**New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form**

Horizant® Medication

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of restless leg syndrome? Yes No

If yes, respond to questions 2–3.

2. Has the patient tried and failed gabapentin IR? Yes No

a. If yes, list date taken and reason for failure:

(Form continued on next page.)



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY (Continued)

3. Has the patient tried and failed or does patient have a contraindication to levodopa/carbidopa, Yes No
pramipexole, or ropinirole?

a. If yes, list medication failed, date taken, and reason for failure or list medication
contraindicated with specific reasons for contraindication:

4. Does the patient have a diagnosis of postherpetic neuralgia? If yes, respond to questions 5 – 6. Yes No

5. Has the patient tried and failed gabapentin or a tricyclic antidepressant? Yes No

a. If yes, list date taken and reason for failure:

6. Has the patient tried and failed pregabalin? Yes No

a. If yes, list date taken and reason for failure:

7. 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: _____