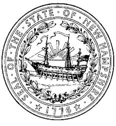

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Oral Isotretinoin 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. Please provide the diagnosis/condition this medication is being prescribed to treat:
2. Has the patient failed at least two conventional acne treatments? ☐ Yes ☐ No
   a. Please list treatment failures and dates:
3. Are patient and provider registered to the iPLEDGE® risk management program and are all requirements met, INCLUDING, if appropriate, a confirmed negative serum pregnancy test and a plan for contraception in place? ☐ Yes ☐ No

(Form continued on next page.)

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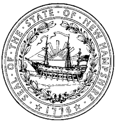

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Oral Isotretinoin Medications

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

4. Has patient used oral isotretinoin therapy in the past? ☐ Yes ☐ No
   a. If *yes*, please provide medication names and dates:
   ____

5. 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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