



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

Topical Retinoids

DATE OF MEDICATION REQUEST:        /        /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

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. Patient's diagnosis for use of this medication (please be complete and use a separate sheet if additional space is required):

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2. Is the medication being used to treat any of the following:

Yes  No

- Photoaging
- Wrinkling
- Hyperpigmentation
- Sun damage
- Melasma

***If you are requesting a non-preferred product, proceed to Section IV.***

*(Form continues on next page.)*



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Topical Retinoids

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**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:**

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

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

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

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Age-specific indications. Provide patient age and explain:

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Unique clinical indication supported by FDA approval or peer-reviewed literature. Explain and provide a reference:

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Unacceptable clinical risk associated with therapeutic change. Please explain:

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**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:** \_\_\_\_\_