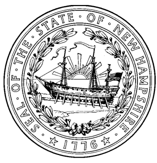

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Asthma/Allergy Immunomodulator

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. For what condition is this medication being prescribed? ____________________
2. Is a pulmonologist, allergist, or immunologist prescribing this medication, or has one of these specialists been consulted in this case? ☐ Yes ☐ No

For an asthma diagnosis request, complete questions 3–8.

3. Is the patient symptomatic despite taking medium-to-high dose of inhaled corticosteroids or oral steroids in combination with either a long-acting $beta_2$ agonist, a leukotriene modifier, or theophylline? ☐ Yes ☐ No
   a. If **yes**, please indicate which medication(s) patient is currently taking: ☐ LABA: ____________________
   ☐ Leukotriene receptor agonist: ____________________ ☐ Theophylline

(Form continued on next page.)

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New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Asthma/Allergy Immunomodulator

DATE OF MEDICATION REQUEST: / /

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

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

SECTION III: CLINICAL HISTORY *(CONTINUED)*

4. Has the patient's allergy been confirmed by skin testing or *in vitro* activity to the allergen? ☐ Yes ☐ No
5. Is the patient poorly compliant on the current asthma treatment plan? ☐ Yes ☐ No
6. Is the patient an active smoker? ☐ Yes ☐ No
7. Is this patient being treated exclusively for a peanut allergy? ☐ Yes ☐ No

For a nasal polyps diagnosis request, complete question 9.

8. Has the patient had an inadequate response to nasal corticosteroids? ☐ Yes ☐ No
   a. If **yes**, please list the nasal corticosteroids below with the dates of therapy.

____

For a hypereosinophilic syndrome diagnosis request, complete questions 10–11.

9. Has the hypereosinophilic syndrome lasted 6 months or longer? ☐ Yes ☐ No
10. Have secondary causes been ruled out? ☐ Yes ☐ No

Provide 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**: ______________

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