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

Duloxetine

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. Does the patient have a diagnosis of a depressive disorder? *If yes, go to question 11.* ☐ Yes ☐ No
2. Does the patient have a diagnosis of generalized anxiety disorder? *If yes, go to question 11.* ☐ Yes ☐ No
3. Does the patient have a diagnosis of diabetic peripheral neuropathy? ☐ Yes ☐ No
4. If **YES** to question 3, has the patient experienced a treatment failure, or is not a candidate for treatment with at least **ONE** of the following agents: any tricyclic antidepressant or gabapentin? ☐ Yes ☐ No
   List treatment failure and dates:

(Form continued on next page.)

Phone: 1-866-675-7755
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Review Date: 10/28/2022

Magellan Rx MANAGEMENT

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

5. Does the patient have a diagnosis of fibromyalgia? *If yes, go to questions 6-9.* ☐ Yes ☐ No
6. Has widespread pain been present for at least 3 months? ☐ Yes ☐ No
7. Is pain present in at least 11 out of the 18 specific tender points (according to ACR guidelines)? ☐ Yes ☐ No
8. Please describe any physical fitness interventions that have been done. **If additional space is needed, please use another page.**

9. Is the patient ≥ 18 years of age and has the patient experienced a treatment failure, or is not a candidate for treatment with at least ONE of the following agents: amitriptyline or cyclobenzaprine? ☐ YES ☐ NO
   a. List treatment failure, maximum doses failed, and dates:

10. Does the patient have a diagnosis of chronic musculoskeletal pain? ☐ YES ☐ NO
    a. Please describe:

    b. If yes to question 10, has the patient experienced a treatment failure, or is not a candidate for treatment with acetaminophen, an NSAID, and cyclooxygenase 2 inhibitors? ☐ YES ☐ NO

11. Is the patient currently on pregabalin or milnacipran? ☐ YES ☐ NO
12. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page.

13. Is the request for brand Cymbalta® or Drizalma® Sprinkle? ☐ YES ☐ NO
    If yes to question 13, please proceed to Section IV (Non-Preferred Drug Approval Criteria).

(Form continued on next page.)

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PATIENT FIRST NAME:

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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