



**New Hampshire Medicaid Fee-for-Service (FFS) Program**

**Prior Authorization/Non-Preferred Drug Approval Form**

Pulmonary Arterial Hypertension – Phosphodiesterase Type-5 (PDE-5) Inhibitor Only

**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 the prescriber a cardiologist or pulmonologist experienced in the diagnosis and treatment of pulmonary hypertension, OR has one of these specialists been consulted in this case?     Yes     No
3. Will the patient be on concurrent organic nitrates, guanylate cyclase stimulators, or other PAH medications?     Yes     No
4. Is the request for sildenafil?     Yes     No
  - a. If Yes, will there be concomitant use with HIV protease inhibitors or elvitegravir/cobicistat/tenofovir/emtricitabine?     Yes     No
5. Is the patient unable to take oral tablets?     Yes     No
  - a. If Yes, please explain: \_\_\_\_\_

*(Form continued on next page.)*



**New Hampshire Medicaid Fee-for-Service (FFS) Program**

**Prior Authorization/Non-Preferred Drug Approval Form**

Pulmonary Arterial Hypertension – Phosphodiesterase Type-5 (PDE-5) Inhibitor Only

**DATE OF MEDICATION REQUEST:**    /    /

---

**PATIENT LAST NAME:**

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

**PATIENT FIRST NAME:**

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

**SECTION III: CLINICAL HISTORY (CONTINUED)**

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