NEW HAMPSHIRE HEALTHY FAMILIES
MEDICATION PRIOR AUTHORIZATION REQUEST FORM

>>> Please DO NOT USE this form for Specialty and/or Biopharmaceutical Requests <<<

Sumbit the request by sending the completed form to US Script by FAX @ 1-866-399-0929
or MAIL to US Script c/o Prior Authorization Department at 5 River Park Place East, Suite 210, Fresno, California 93720

I. MEMBER INFORMATION		II. PRESCRIBER INFORMATION	
Name:		Name:	
ID Number:		Specialty:	
Gender:		NPI or DEA Number:	
Date of Birth:		Group or Hospital:	
Address:		Address:	
City, State, Zip:		City, State, Zip:	
Primary Phone:		Phone:	
Alternate Phone:		Fax:	
Medication Allergies:		Office Contact Name:	

III. MEDICATION REQUESTED (one medication request per form)			
Drug Name:		Dosage/Strength:	
Dosage Form:		Route of Admin:	
Quantity Per Day:		Directions:	
Refills/Length of Tx:		Therapy Start Date:	

IV. DIAGNOSIS (as relevant to this request)			
Diagnosis:		ICD9 and Description:	
Date of Diagnosis:		***NOTE: Include diagnostic clinicals (labs, radiology, etc.).***	

V. MEDICATION HISTORY (for this diagnosis)

A. Is the member currently on this medication? ☐**Yes**; how long? _____ ☐**No**; skip to items B&C, go to **D**.

B. Is this a request for continuation of a previous approval? ☐**Yes**; go to item **C**. ☐**No**; skip item C, go to **D**.

C. Has the strength, dosage, or quantity required per day: ☐**INCREASED** ☐**DECREASED** ☐Remained the **SAME**

D. Indicate PREVIOUS medications treatment/outcomes below. ***NOTE: Confirmation will be made using claims history.***

	Drug Name, Strength, and Dosage	Dates of Therapy	Reason for Discontinuation
1			
2			
3			
4			

VI. RATIONALE FOR REQUEST and PERTINENT CLINICAL INFORMATION

NOTE: Appropriate clinical information to support this request is required for all PA's. Attach additional sheets if more space is needed.

☐ Medical intolerance to the preferred drug. Provide clinical symptoms.
☐ Inadequate response to the preferred drug.
☐ Absence of appropriate formulation or indication of the drug. Please specify.
☐ Other – Provide rationale for the request.

Prescriber Signature – **Dispense as Written (DAW)**:

X_____ Date: _____

Prescriber Signature – **Substitution Permitted**:

X_____ Date: _____

Please access http://www.NHhealthyfamilies.com/ or contact provider services for a current listing of preferred products. A response will be provided via fax or phone within one business day of the receipt of the complete information. Incomplete and illegible forms will delay processing. Be sure to include lab reports with requests when appropriate. **To request a 72 hour emergency supply of medication you may call US Script at 1-877-250-5227. *NOTE: The 72 hour supply does not apply to specialty medications.*** Requests can also be mailed to: US Script, c/o Prior Authorization Department, 5 River Park Place East, Suite 210, Fresno, CA 93720.