



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

Hematopoietic Agent

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION IV: REQUIRED LAB RESULTS

LAB RESULTS:

DATE OF LAB WORK:

Patient's **current** hematocrit and hemoglobin levels:

Patient's **baseline** hematocrit and hemoglobin levels:

Patient's **target** hematocrit and hemoglobin levels:

Patient's **current** transferrin saturation and ferritin levels:

2. What is the plan for decreasing dose or discontinuing medication once patient has achieved goal? Describe.

Provide any additional information that would help in the decision-making process. **If additional space is needed, please use a separate sheet.**

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:**

Phone: 1-866-675-7755

Fax: 1-888-603-7696