



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

Hematopoietic Agent

DATE OF MEDICATION REQUEST:    /    /

**SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED**

LAST NAME:

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

FIRST NAME:

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

MEDICAID ID NUMBER:

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

DATE OF BIRTH:

				-					-				
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GENDER:     Male     Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

**SECTION II: PRESCRIBER INFORMATION**

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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**SECTION III: CLINICAL HISTORY**

1. For what condition is this medication being prescribed? **Select all that apply:**

- |   |   |
|---|---|
| <input type="checkbox"/> Anemia associated with chronic kidney disease    | <input type="checkbox"/> Anemia associated with prior chemotherapy                      |
| <input type="checkbox"/> Anemia associated with cancer chemotherapy       | <input type="checkbox"/> Anemia in myelodysplastic syndromes (MDS)                      |
| <input type="checkbox"/> Anemia in HIV-infected patient treated with AZT  | <input type="checkbox"/> Anemia in lymphoproliferative disorder                         |
| <input type="checkbox"/> Patient with Hepatitis C on ribavirin            | <input type="checkbox"/> Anemia associated with prior radiation therapy                 |
| <input type="checkbox"/> Anemia associated with current radiation therapy | <input type="checkbox"/> Reduction of allogeneic blood transfusions in surgery patients |
| <input type="checkbox"/> Anemia associated with malignancy                | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Patient is on dialysis or is pre-dialysis        |   |

Form continued on the next page.





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Hematopoietic Agent

**DATE OF MEDICATION REQUEST:**    /    /

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**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

