

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

Hyaluronic Acid Derivatives Injection

DATE OF MEDICATION REQUEST: /

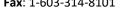
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SECTION I: PATIENT INFORMATION AND MEDICATION REQU	JESTED												
LAST NAME:	FIRST NAME:												
MEDICAID ID NUMBER:	DATE OF BIRTH:												
GENDER: Male Female													
Drug Name:	Strength:												
Dosing Directions:	Length of Therapy:												
Number of Injections Required/Requested:		HCPC Code:											
SECTION II: PRESCRIBER INFORMATION													
LAST NAME:	FIRST NAME:												
SPECIALTY:	NPI NUMBER:												
PHONE NUMBER:	FAX NUMBER:												
	-	_											
MEDICAID PROVIDER NUMBER:													
SECTION III: CLINICAL HISTORY													
1. What is the patient's diagnosis for use of this medica separate sheet if additional space is required)?	tion (please be com	nplete and use a											
2. Is there evidence of severe bone-on-bone osteoarthritis of the knee?													

Fax to Prime Therapeutics Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.

**Phone**: 1-866-675-7755 **Fax**: 1-888-603-7696

Fax to DHHS if medication is dispensed/administered by the office or outpatient setting:

**Phone**: 1-603-271-9384 **Fax**: 1-603-314-8101







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PΑ	TIENT	LAS	T NAI	ME:								PATIENT FIRST NAME:											
				<u> </u>																			
SE	SECTION III: CLINICAL HISTORY (CONTINUED)																						
3.	3. Has there been a trial and failure of (or contraindication to) non-pharmacologic therapy?																Yes	N	0				
	If yes, please describe (use a separate sheet if additional space is required):																						
1	Has there been a trial and failure of analgesics?															,	Yes	□и	0				
٦.	Has there been a trial and failure of analgesics?												ш	ics [	'\	U							
	If yes, please describe (use a separate sheet if additional space is required):																						
5.	5. Has there been a trial and failure of aspiration and injection of intra-articular steroids?														Yes	N	0						
	If yes, please describe (use a separate sheet if additional space is required):																						
6.	5. Does the patient report pain with functional activities?														,	Yes	⊐и	0					
/.	7. Is there any evidence of infection or skin disease in the area of injection?													Ш	Yes	N	O						
	If <i>yes</i> , please describe (use a separate sheet if additional space is required):																						
8.	3. Is there any additional information that would help in the decision-making process?														Yes	N	0						
If yes, please describe (use a separate sheet if additional space is required):																							
Lo	ortify t	hat t	ha inf	ormat	ion nr	ovido	d is ac	curate	a and	comn	lota	2 to t	ho ho	st of	my k	nowl	odgo	and I	unda	_ rctan	d that	tany	
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.																							
		-								•		=						•					
PR	ESCRI	BER'	s sig	NATU	RE:							DATE:											

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