



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

Hyaluronic Acid Derivatives Injection

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:

 Male

 Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

Number of Injections Required/Requested:

HCPC Code:

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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MEDICAID PROVIDER NUMBER:

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SECTION III: CLINICAL HISTORY

1. What is the patient’s diagnosis for use of this medication (please be complete and use a separate sheet if additional space is required)?

2. Is there evidence of severe bone-on-bone osteoarthritis of the knee? Yes No

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



