



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

Vuity®

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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

FIRST NAME:

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

MEDICAID ID NUMBER:

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

DATE OF BIRTH:

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

GENDER:

☐ Male

☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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

FIRST NAME:

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

SPECIALTY:

NPI NUMBER:

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

PHONE NUMBER:

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

FAX NUMBER:

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

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of presbyopia? ☐ Yes ☐ No
2. Is the prescriber an optometrist or ophthalmologist **or** has one been consulted? ☐ Yes ☐ No
3. Does the patient have glaucoma, ocular hypertension, or iritis? ☐ Yes ☐ No
4. Does the patient have a documented contraindication or failure of corrective lenses? ☐ Yes ☐ No
List failure or note contraindication:
Eyeglasses: _____
Contacts: _____

SECTION IV: FOR RENEWALS ONLY

1. Has the patient demonstrated efficacy with improvement in presbyopia? ☐ Yes ☐ No
2. Has the patient experienced any treatment-limiting adverse effects (e.g., retinal detachment, iritis, hypersensitivity)? ☐ Yes ☐ No



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

Vuity®

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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

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

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:** _____