



**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:

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

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:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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

PHONE NUMBER:

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FAX NUMBER:

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

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 Magellan Rx 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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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

Grid for patient last name

PATIENT FIRST NAME:

Grid for patient first name

SECTION III: CLINICAL HISTORY (CONTINUED)

3. Has there been a trial and failure of (or contraindication to) non-pharmacologic therapy? Yes No

If yes, please describe (use a separate sheet if additional space is required):

4. Has there been a trial and failure of analgesics? Yes No

If yes, please describe (use a separate sheet if additional space is required):

5. Has there been a trial and failure of aspiration and injection of intra-articular steroids? Yes No

If yes, please describe (use a separate sheet if additional space is required):

6. Does the patient report pain with functional activities? Yes No

7. Is there any evidence of infection or skin disease in the area of injection? Yes No

If yes, please describe (use a separate sheet if additional space is required):

8. Is there any additional information that would help in the decision-making process? Yes No

If yes, please describe (use a separate sheet if additional space is required):

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:

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