



# 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:

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FIRST NAME:

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MEDICAID ID NUMBER:

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

DATE OF BIRTH:

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

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        |   |

## 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: \_\_\_\_\_

1. Is there a 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: \_\_\_\_\_