



# 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

<b>Patient's Name</b>	<b>Medicaid Number</b>
<input type="text"/>	<input type="text"/>
<b>Date of Birth (MM/DD/YYYY)</b>	<b>Gender</b>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female
<b>Drug Name</b>	<b>Strength</b>
<input type="text"/>	<input type="text"/>
<b>Dosing Schedule</b>	<b>Length of Therapy</b>
<input type="text"/>	<input type="text"/>
<b>Number of Injections Required/Requested</b>	<b>HCPC Code</b>
<input type="text"/>	<input type="text"/>

## SECTION II: PRESCRIBER INFORMATION

<b>LAST NAME:</b>	<b>FIRST NAME:</b>
<input type="text"/>	<input type="text"/>
<b>SPECIALTY:</b>	<b>NPI NUMBER:</b>
<input type="text"/>	<input type="text"/>
<b>PHONE NUMBER:</b>	<b>FAX NUMBER:</b>
<input type="text"/> - <input type="text"/> - <input type="text"/>	<input type="text"/> - <input type="text"/> - <input type="text"/>
<b>MEDICAID PROVIDER NUMBER</b>	
<input type="text"/>	

## SECTION III: CLINICAL HISTORY

1. 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
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. 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): \_\_\_\_\_
6. 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:** \_\_\_\_\_

Fax to Magellan Rx Management if medications can be dispensed from a pharmacy.

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: 1-603-271-8194

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

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