HYALURONIC ACID DERIVATIVES INJECTION

New Hampshire Medicaid Prior Authorization Request Form

Fax to Magellan if medication is to be dispensed from a pharnacy

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

Fax to Schaller Anderson if medication is dispensed/administered by a physician in the office or outpatient setting:

Schaller Anderson Fax: 1-866-499-9334 Phone: 1-866-499-9335

Date of Medication Request: ___ ___ /___ ___ /___ ___ _

Section I: Patient Information and Medication Requested

Name (Last, First): _____

NH Medicaid Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____

Date of Birth: ___ ___ /___ ___ /___ ___ ___ ___ Gender: ☐ Male ☐ Female

Drug Name: _____ Strength: _____

Dosing Schedule: _____ _____ Length of Therapy: From __/__/____ to __/__/____

Number of injections required/requested: _____

Section II: 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 the patient allergic to latex? ☐ Yes ☐ No

6. 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):

_____

7. Is there any additional information that would help in the decision-making process? (use a separate sheet if additional space is required)

_____

Section III: Prescriber Information

Medicaid Provider ID# _____

Name: _____ NPI: _____

Phone Number: (__ ___ ___) ___ ___ ___ - ___ ___ ___ ___ Fax Number: (__ ___ ___) ___ ___ ___ - ___ ___ ___ ___

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.

_____

Signature of Prescribing Provider