



**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:

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

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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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 | |

Form continued on the next page.



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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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:	_____	_____

2. What is the 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: _____