

## **New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form**

Hematopoietic Agent

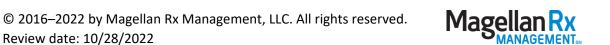
DATE OF MEDICATION REQUEST: /	/											
SECTION I: PATIENT INFORMATION AND MEDICATION	REQUESTED											
LAST NAME:	FIRST NAME:											
MEDICAID ID NUMBER:	DATE OF BII	RTH:										
		_		_				]				
CENTED: Andrew Transle												
GENDER: Male Female  Drug Name:	Strength:											
Dosing Directions:		Length of Therapy:										
SECTION II: PRESCRIBER INFORMATION												
LAST NAME:	FIRST NAMI	E:										
SPECIALTY:	NPI NUMBE	R:										
								]				
PHONE NUMBER:	FAX NUMBE	 ER:						J				
					_							
SECTION III: CLINICAL HISTORY												
1. For what condition is this medication being prescribed	? Select all tha	at apply	<b>/</b> :									
Anemia associated with chronic kidney disease	Anemia associated with prior chemotherapy											
Anemia associated with cancer chemotherapy	☐ Anemia in myelodysplastic syndromes (MDS)											
Anemia in HIV-infected patient treated with AZT	Anemia in lymphoproliferative disorder											
Patient with Hepatitis C on ribavirin	Anemia associated with prior radiation therapy											
Anemia associated with current radiation therapy												
Anemia associated with malignancy	patients Other:											

Form continued on the next page.

**Phone**: 1-866-675-7755

Fax: 1-888-603-7696

Patient is on dialysis or is pre-dialysis





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DATE OF MEDICATION REC	QUEST:	1		/											
PATIENT LAST NAME:		PATIEN			NT FI	RST	NAN	⁄ΙΕ:							
CECTION IV. DECLUDED LAD DECLUTS															
SECTION IV: REQUIRED LAB RESULTS  LAB RESULTS:									D/	ΔΤF (	)F I 4	R W	ORK:		
Patient's current hematocrit and											), L	1D VV	OIII.		
hemoglobin levels:															
Patient's <b>baseline</b> hematocrit and hemoglobin levels:															
Patient's <b>target</b> hematocrit and hemoglobin levels:															
Patient's <b>current</b> transferrin saturation and ferritin levels:															
Provide any additional information that please use a separate sheet.	would I	help in t	he o	decisio	n-ma	akinį	g pro	cess.	If ac	dditi	onal	spac	e is n	eede	d,
I certify that the information provided that any falsification, omission, or cond				=				=			_				d
PRESCRIBER'S SIGNATURE:								D/	ATE:						

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