Reset Form Print Form

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

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

Number of Injections Required/Requested:

HCPC Code:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

MEDICAID PROVIDER NUMBER:

SECTION III: CLINICAL HISTORY

1. What is the 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

Fax to Prime Therapeutics Management if medications will be dispensed by a pharmacy and will be administered by the patient or caregiver at home.
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: 1-603-314-8101

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Review Date: 12/04/2024

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(CONTINUED)*

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. Has there been a trial and failure of aspiration and injection of intra-articular steroids? ☐ Yes ☐ No

   If *yes*, please describe (use a separate sheet if additional space is required):

6. Does the patient report pain with functional activities? ☐ Yes ☐ No

7. 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):

8. 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**: _____

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