

New Hampshire AIDS Drug Assistance Program Prior Authorization Drug Approval Form

DATE OF MEDICATION REQUEST: /	/												
SECTION I: PATIENT INFORMATION AND MEDICATION F	REQUESTED												
LAST NAME:	FIRST NAME:												
MEDICAID ID NUMBER:	DATE OF BIRTH:												
GENDER: Male Female													
Drug Name:	Strength:												
Dosing Directions:	Length of Therapy:												
SECTION II: PRESCRIBER INFORMATION													
LAST NAME:	FIRST NAME:												
SPECIALTY:	NPI NUMBER:												
PHONE NUMBER:	FAX NUMBER:												
SECTION III: CLINICAL HISTORY													
L. For what condition is this medication being prescribed?	Select all that apply:												
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	Reduction of allogeneic blood transfusions in surgery												

patients

Other:

Form continued on the next page.

Anemia associated with malignancy

Patient is on dialysis or is pre-dialysis





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Hematopoietic Agent

DATE OF MEDICATION REC	QUEST:	/		/													
PATIENT LAST NAME:	AST NAME:				PATIENT FIRST NAME:												
SECTION IV: REQUIRED LAB RESULTS																	
LAB RESULTS:									DA	ATE (OF L	AB W	/ORK:				
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:																	
Provide any additional information that please use a separate sheet.	would he	elp in th	e de	ecisior	n-ma	aking	g pro	cess.	If a	dditi	ional	spa	ce is n	eede	ed,		
I certify that the information provided i that any falsification, omission, or conc			_					_			_				d		
PRESCRIBER'S SIGNATURE:								D/	ATE:								

Phone: 1-800-424-7901 Fax: 1-800-424-7984

