



HYALURONIC ACID DERIVATIVES INJECTION



SCHALLER ANDERSON

NH Medicaid Prior Authorization Request Form

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 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):

5. 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

Name: _____ Medicaid Provider ID Number: _____

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