



RHEUMATOID ARTHRITIS MEDICATIONS



SCHALLER ANDERSON

NH Medicaid Prior Authorization Request Form

Fax to First Health if medication is to be dispensed from a pharmacy

First Health: Fax: 1-888-603-7696 Phone: 1-866-675-7755

Fax to Schaller Anderson if medication is dispensed and administered by a physician

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: _____

2. Previous failure, contraindication, or adverse reaction to methotrexate: Yes No

3. Prior or current use of a DMARD (sulfasalazine, hydroxychloroquine, azathioprine, D-penicillamine, gold salts, or cyclosporine): Yes No

4. Is there any additional information that would help in the decision-making process? If additional space is needed, please use another page. _____

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