New Hampshire Medicaid HCPCS (Healthcare Common Procedure Coding System) Authorization Form

Confidential information

Patient name:			
Patient date of birth (MM/DD/YYYY): / /		Patient ID number:	
Physician name:		Specialty:	
Phone:	Fax:		NPI:
Physician street address:			
City:		State:	ZIP code:
Facility name:		Facility NPI:	
Medication name and strength requested:		J-code: NDC#: Number of units: Date of service (MM/DD/YYYY): / /	
Directions:			
Anticipated length of therapy: ☐ Days ☐ 3 months ☐ 6 months			
Treatment setting: ☐ Outpatient ☐ Home infusion ☐ In-office ☐ Other:			
Diagnosis:			
Preferred medications tried/Previous therapy. Please include strength, frequency, and duration. (If medications were tried prior to enrollment, or if office samples were given, please include chart notes and/or sample logs.)			
Rationale and/or additional information that may be relevant to the review of this prior authorization request. (If more space is needed, please attach an additional page to this document.)			
Physician signature:		Date (MM/DD/YYYY): / /	

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