AmeriHealth Caritas New Hampshire

Hematopoietic Agent

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information			
Prescriber last name:		Prescriber first name:	
Prescriber address:		Prescriber representative:	
Specialty:		NPI number:	
Phone #:	Fax #:		

Clinical history

1. For what condition is this medication being prescribed? Select all that apply:

- ☐ Anemia associated with chronic kidney disease
- ☐ Anemia associated with cancer chemotherapy
- ☐ Anemia in HIV-infected patient treated with AZT
- ☐ Patient with Hepatitis C on ribavirin
- ☐ Anemia associated with current radiation therapy
- ☐ Anemia associated with malignancy
- ☐ Patient is on dialysis or is pre-dialysis
- ☐ Anemia associated with prior chemotherapy
- ☐ Anemia in myelodysplastic syndromes (MDS)
- ☐ Anemia in lymphoproliferative disorder
- ☐ Anemia associated with prior radiation therapy
- ☐ Reduction of allogeneic blood transfusions in surgery patients
- ☐ Other:

Required lab results

Lab results	Date of lab work
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:	

1. Is there a plan for decreasing dose or discontinuing medication once patient has achieved goal? Describe.

Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

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.