AmeriHealth Caritas New Hampshire

Hyaluronic Acid Derivatives Injection

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 schedule:	Length of therapy:
Number of injections required/requested:	HCPC code:

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

Clinical history
Patient's diagnosis for use of this medication (please be complete and use a separate sheet if additional space is required): ☐ Yes ☐ No
Is there evidence of severe bone on bone osteoarthritis of the knee? ☐ Yes ☐ No
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):
Has there been a trial and failure of analgesic? ☐ Yes ☐ No If yes, please describe (use a separate sheet if additional space is required):
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):
Is there any additional information that would help in the decision-making process? ☐ Yes ☐ No If yes, please describe (use a separate sheet if additional space is required):

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.