New Hampshire Medicaid Fee-for-Service Program Prior Authorization Drug Approval Form

Vuity®

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME: **FIRST NAME:**

MEDICAID ID NUMBER: **DATE OF BIRTH:** – –

GENDER: ☐ Male ☐ Female

Drug Name: **Strength:**

Dosing Directions: **Length of Therapy:**

SECTION II: PRESCRIBER INFORMATION

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: – – **FAX NUMBER:** – – –

SECTION III: CLINICAL HISTORY

1. Does the patient have a diagnosis of presbyopia? ☐ Yes ☐ No
2. Is the prescriber an optometrist or ophthalmologist **or** has one been consulted? ☐ Yes ☐ No
3. Does the patient have glaucoma, ocular hypertension, or iritis? ☐ Yes ☐ No
4. Does the patient have a documented contraindication or failure of corrective lenses? ☐ Yes ☐ No
   List failure or note contraindication:
   Eyeglasses: _____
   Contacts: _____

SECTION IV: FOR RENEWALS ONLY

1. Has the patient demonstrated efficacy with improvement in presbyopia? ☐ Yes ☐ No
2. Has the patient experienced any treatment-limiting adverse effects (e.g., retinal detachment, iritis, hypersensitivity)? ☐ Yes ☐ No

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PATIENT LAST NAME:	**PATIENT FIRST NAME:**

Provide any additional information that would help in the decision-making process. **If additional space is needed, please use another page.**

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.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

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

Magellan Rx MANAGEMENT