New York State Medicaid
Practitioner Administered Drug Standard Clinical Criteria Worksheet

Completed worksheet must be submitted with the Medical Assistance Health Insurance Claim Form, Additional information can be found here: New York State Medicaid Fee-for-Service Practitioner Administered Drug

Enrollee Information

Enrollee Last Name: _____

Enrollee First Name: _____

Date of Birth (MM/DD/YYYY): ☐☐ / ☐☐ / ☐☐☐☐

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): ☐☐☐☐☐☐☐☐☐

Prescriber Information

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____ **Specialty:** _____

Prescriber Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Prescriber Phone: _____ **Prescriber Fax:** _____

Did the ordering prescriber administer the medication? ☐ **Yes** ☐ **No**

If No, who administered? ☐ **Another provider** ☐ **Facility** ☐ **Self** ☐ **Other**

Name of person who administered: _____

Drug Information

Drug Name: _____

Drug Strength: _____

Date of drug administration (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐

Route of Administration (please check one)

☐ **Oral** ☐ **Intramuscular** ☐ **Subcutaneous** ☐ **Transdermal** ☐ **Intravenous**

☐ **Other:** _____

Enrollee Last Name: **Enrollee First Name:**

_____ _____

Clinical Information

Diagnosis #1: **ICD-10 Code:**

_____ _____

Diagnosis #2 **ICD-10 Code:**

_____ _____

Enrollee weight (in kg): **Enrollee height (in/cm):**

_____ _____

Please check one of the following:

☐ **New medication** ☐ **Continued therapy previously covered by another benefit**

If *Continued* was checked, is this a change in dose? ☐ **Yes** ☐ **No**

If *Continued* was checked, please provide approximate date therapy was initiated:

☐☐ / ☐☐ / ☐☐☐☐

Are the relevant lab results, tests, and diagnostic studies that were performed to support the use of the drug included?

☐ **Yes** ☐ **No**

Check the box below to indicate the genetic testing results are included with the submission of this worksheet. (A copy of the genetic testing confirming the diagnosis is required for gene therapy.)

☐ **Yes** ☐ **No**

Have precaution/contraindication been reviewed before starting therapy?

☐ **Yes** ☐ **No**

Have dose changes or monitoring parameters been performed for hepatic or renal impairment?

☐ **Yes** ☐ **No**

Enrollee Last Name: **Enrollee First Name:**

_____ _____

Is the patient concurrently utilizing other therapies for the above diagnosis? (example: DMARD-Drug-Modifying Antirheumatic Drugs) ☐ **Yes** ☐ **No**

If *Yes*, explain:

_____

Has the patient tried and discontinued other therapies for the above diagnosis? ☐ **Yes** ☐ **No**
If *Yes*, explain: (treatment failure, adverse reaction, allergy)

_____

Is the drug being used for an FDA-approved indication, as described in the *Indications and Usage* section of the drug's Prescribing Information? ☐ **Yes** ☐ **No**

If *No* was checked, is the drug's use supported by Official Compendia (AHFS Drug Information®, DRUGDEX®)? ☐ **Yes** ☐ **No**

Attestation

I attest that this drug is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by the New York State Medicaid Program.

_____ _____

Signature of Prescriber (Required) **Date (MM/DD/YYYY)**