

CONTINUATION:

f. NUMBER OF VASO-OCCLUSIVE CRISES PATIENT EXPERIENCED IN THE MOST RECENT 12 MONTHS? _____

g. NUMBER OF VASO-OCCLUSIVE CRISES PATIENT EXPERIENCED IN THE MOST RECENT 24 MONTHS? _____

II. SCD DISEASE TREATMENT/MEDICATION HISTORY

	RELEVANT MEDICATION HISTORY	DAILY DOSE	START DATE	END DATE	OUTCOME OR WHY DISCONTINUED?
1					
2			/ /	/ /	
3			/ /	/ /	
4			/ /	/ /	

III. ATTACHMENT: COPY OF MOST RECENT CLINICAL VISIT NOTES

IV. OTHER RELEVANT CLINICAL INFORMATION/DIAGNOSES

PRESCRIBER ATTESTATION AND SIGNATURE _____ DATE _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS S/HE IS AUTHORIZED TO PRESCRIBE THIS MEDICATION BY RI MEDICAID AND THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

<p>FOR STATE USE ONLY:</p> <p>APPROVAL: _____ YES _____ NO PRIOR AUTHORIZATION #: _____</p> <p>EFFECTIVE DATES: FROM: _____ TO _____</p>
