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

Psychoactive Medications (Antipsychotics, Antidepressants, Anti-Anxiety, Sedative Hypnotics, Mood Stabilizers, Anti-Mania Agents) **for Children (5 years of age or younger)**

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. Is the patient ≤ 5 years of age? ☐ Yes ☐ No
2. Is there documented evidence of one of the following? ☐ Yes ☐ No

   ☐ Patient is **receiving**:

   ☐ psychiatric, ☐ neurology, or ☐ developmental pediatric therapy/consult

   ☐ Patient is **on a waiting list for**:

   ☐ psychiatric, ☐ neurology, or ☐ developmental pediatric therapy/consult
3. Does the patient have a diagnosis of Tourette's and tic disorders? ☐ Yes ☐ No

(Form continued on next page.)

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

Review Date: 01/29/2024

Magellan Rx MANAGEMENT℠

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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

4. Does the patient have a diagnosis of seizure disorder? ☐ Yes ☐ No

5. Is there 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**: _____

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