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

Psychotropic Medications (Antipsychotics, Antidepressants, Anti-Anxiety, Sedative Hypnotics, Mood Stabilizers, Anti-Mania Agents) **Duplicate Therapy (6 years of age or older)**

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 ≥ 6 years of age? ☐ Yes ☐ No
2. Are all duplicate psychotropic medications (within the same psychotropic therapeutic class) prescribed by the same prescriber? ☐ Yes ☐ No
3. Please provide the diagnosis for the psychotropic medications:

(Form continued on next page.)

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

SECTION III: CLINICAL HISTORY *(Continued)*

4. Is there documented evidence that the duplicate drug(s) are for a non-psychiatric indication? ☐ Yes ☐ No

   a. If *yes*, please provide the non-psychiatric indication:

   _____

5. 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

6. 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**: _____