New Hampshire Medicaid Fee-for-Service Program Psychotropic Medication Duplicate Therapy (Patients 6 Years and Older) Criteria

Approval Date: June 5, 2025

Psychotropic Therapeutic Classes

Antipsychotic, antidepressant, anti-anxiety, sedative hypnotics, mood stabilizers, anti-mania agents

Duplicate Therapy Criteria

1. More than one medication prescribed within the same psychotropic therapeutic class within 60 days look back period.
2. **Exception to Duplicate Therapy Criteria:**
   a. All applicable prescriptions are by the same prescriber and there is documentation that monotherapy has been inadequate or limited by side effects; **OR**
   b. There is documentation that the duplicate drug is for a non-psychiatric indication (the non-psychiatric indication must be provided).

Criteria for Approval

1. Documented evidence that patient is receiving or has received psychiatry, neurology, or developmental pediatrician consultation; **AND**
2. Patient has a diagnosis in accordance with current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Criteria for Denial

Prior approval will be denied if the approval criteria are not met.

Length of Approval: 12 months

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	10/28/2019
Commissioner Designee	Approval	12/03/2019

Reviewed by	Reason for Review	Date Approved
DUR Board	Review	12/15/2020
Commissioner Designee	Approval	02/24/2021
DUR Board	Revision	06/02/2022
Commissioner Designee	Approval	07/12/2022
DUR Board	Revision	12/08/2023
Commissioner Designee	Approval	01/22/2024
DUR Board	Revision	04/08/2025
Commissioner Designee	Approval	06/05/2025