Reset Form Print Form

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

Codeine for Pediatric Use

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 medication being prescribed for post-surgical pain following tonsil or adenoid procedure? ☐ Yes ☐ No
2. Is the patient obese (BMI > 95th percentile per CDC guidelines)? ☐ Yes ☐ No
3. Does the patient have obstructive sleep apnea or severe lung disease? ☐ Yes ☐ No
4. Has the patient tried and failed or is not a candidate for at least 2 of the following? Provide details below.
   a. Topical NSAIDS:
   b. Oral NSAIDS
   c. Oral Acetaminophen:

Please describe treatment failures and provide dates:

(Form continued on next page.)

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

Review Date: 11/01/2025

Prime THERAPEUTICS™

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PATIENT LAST NAME:

PATIENT FIRST NAME:

SECTION III: CLINICAL HISTORY *(Continued)*

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

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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