



# 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:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER:     Male         Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

## SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

				-					-				
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FAX NUMBER:

				-					-				
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## 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.)*

