



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:

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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.)



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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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PATIENT FIRST NAME:

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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:** _____