



**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:

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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 ≥ 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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DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:

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

PATIENT FIRST NAME:

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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:** _____