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:

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 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.)

Magellan Rx MANAGEMENT℠

DATE OF MEDICATION REQUEST: _____ / _____ / _____

PATIENT LAST NAME:

PATIENT FIRST NAME:

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**: _____