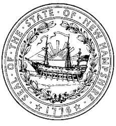

New Hampshire Medicaid –Managed Care Organization (MCO)
Community Mental Health Center
Prior Authorization/Mental Health Drug Approval Form

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED **ALL INFORMATION MUST BE COMPLETED**

LAST NAME: **FIRST NAME:**

MEMBER ID NUMBER: **DATE OF BIRTH:** - -

GENDER: ☐ Male ☐ Female

Medical Diagnosis:____

Drug Name:_________________________________ **Strength:**________________________ ☐ **Brand Medically Necessary** Please explain:

Dosing Directions: **Length of Therapy:**

Is this request for initial or continuing therapy? If continuing therapy, provide treatment start date. **Start Date**

SECTION II: PRESCRIBER INFORMATION **ALL INFORMATION MUST BE COMPLETED**

LAST NAME: **FIRST NAME:**

SPECIALTY: **NPI NUMBER:**

PHONE NUMBER: - - **FAX NUMBER:** - -

SECTION III: MEDICAL HISTORY **<u>**AN EXPLANATION MUST BE PROVIDED FOR EACH BOX CHECKED IN ORDER TO BE PROCESSED**</u>**

CHAPTER 188 OF THE LAWS OF 2004 REQUIRES THAT MEDICAID ONLY COVER NON-PREFERRED DRUGS UPON A FINDING OF MEDICAL NECESSITY BY THE PRESCRIBING PHYSICIAN. CHAPTER 188 REQUIRES THAT YOU BASE YOUR DETERMINATION OF MEDICAL NECESSITY ON THE FOLLOWING CRITERIA.

☐ Allergic reaction ☐ Drug-to-drug interaction **Please describe reaction:**

☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:

☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to a preferred drug. Please provide clinical information:

☐ Age specific indications. Please provide patient age and explain:

☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and if possible provide a reference:

☐ Unacceptable clinical risk associated with therapeutic change. *Additional information required*:

- ☐ Client is under a Conditional Discharge or Outpatient Treatment Order and is psychiatrically stable on this medication.
- ☐ Client discharged from inpatient psychiatric unit within the past 30 days and is psychiatrically stable on this medication.
- ☐ Client is receiving ACT services and is psychiatrically stable on this medication.
- ☐ Other. Please explain:

☐ Please attach or provide any pertinent medical information that should be considered including labs when appropriate.

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**: ________________________________

Prescriber's Printed Name :____Phone Number:________________________________

Contact Person for scheduling of Peer to Peer:______________________________ Phone Number:_________________________________

NH Healthy Families/Envolve Fax 1-866-399-0929 Well Sense Health Plan /EnvisionRX Fax: 1-866-305-5739

AmeriHealth Caritas/PerformRx Fax 1-855-839-3883