

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

Prior Authorization/Mental Health Drug Approval Form

DATE OF MEDICATION REQUEST:

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED **ALL INFORMATION MUST BE COMPLETED**		
AST NAME:	FIRST NAME:	
MEMBER ID NUMBER:	DATE OF BIRTH:	
GENDER: Male Female	_	-
Medical Diagnosis		
Drug Name		Strength
Dosing Directions		Length of Therapy
s this request for initial or continuing therapy? If continuing therapy, provide treatment start date. Start Date		
SECTION II: PRESCRIBER INFORMATION **ALL INFORMATION MUST BE COMPLET	TED**	
LAST NAME:	FIRST NAME:	
SPECIALTY:	NPI NUMBER:	
PHONE NUMBER:	FAX NUMBER:	
SECTION III: MEDICAL HISTORY **AN EXPLANATION MUST BE PROVIDED FOR EACH BOX CHECKED IN ORDER TO BE PROCESSED** 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. Please describe		
Allergic reaction Drug-to-drug interaction		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 stient age and explain:		
Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a reference:		
Unacceptable clinical risk associated with therapeutic change. Additional information	ation 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. Other. Please explain: 		
Please attach or provide any pertinent medical information that should be considered.		
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: