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

AmeriHealth Caritas New Hampshire

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** (Explain below)

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:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____

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.

☐ 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: _____

PerformRx Fax: 1-866-880-3679 PerformRx Call Center: 1-888-765-6394

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