



**New Hampshire Medicaid Fee-for-Service Program Prior Authorization
Drug Approval Form**

Psychotropic Medications (Antipsychotic, Antidepressant, 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:

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

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 \geq 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.)

