



New Hampshire AIDS Drug Assistance Program

Prior Authorization

Antipsychotic Polypharmacy

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. Has the patient received or is the patient currently receiving a psychiatry consultation? Yes No

2. Is the patient's diagnosis found in the current Diagnostic and Statistical Manual of Mental Disorders (DSM)? Yes No

If yes, provide the diagnosis: _____

3. Is there a titration plan for one or more of the antipsychotic medications? Yes No

If yes, provide details of the plan: _____

If no, provide details of the treatment plan: _____

4. Provide a monitoring schedule.

Phone: 1-800-424-7901 Fax: 1-800-424-7984

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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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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:** _____