



New Hampshire AIDS Drug Assistance Program (ADAP)
Prior Authorization Drug Approval Form

Codeine for Pediatric Use

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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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:

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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:

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

SECTION III: CLINICAL HISTORY

1. Is the medication being prescribed for post-surgical pain following tonsil or adenoid procedure? ☐ Yes ☐ No
2. Is the patient obese (BMI > 95th percentile per CDC guidelines)? ☐ Yes ☐ No
3. Does the patient have obstructive sleep apnea or severe lung disease? ☐ Yes ☐ No
4. Has the patient tried and failed or is not a candidate for at least 2 of the following? Provide details below.

a. Topical NSAIDs:

b. Oral NSAIDs

c. Oral Acetaminophen:

Please describe treatment failures and provide dates:

(Form continued on next page.)



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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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SECTION III: CLINICAL HISTORY *(Continued)*

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

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:** _____

Phone: 1-800-424-7901

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