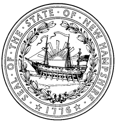

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form

Codeine for Pediatric Use

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. 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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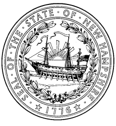

New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form
Codeine for Pediatric Use

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:	**PATIENT FIRST NAME:**

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: 1-866-675-7755
Fax: 1-888-603-7696

MagellanRx MANAGEMENT