



**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:

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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 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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DATE OF MEDICATION REQUEST: / /

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:** _____