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| **Client Information** | First Name, Last Name:      | Clt. ID #:       | Date of Birth (MM/DD/YYYY):      | Gender:      | Date Requested:\*      |
| Requested Medication and Strength:      | [ ]  Initial[ ]  Continued  |
| Primary Diagnosis/Relevant Medical Condition(s)/Substance Use Disorder(s)      |

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| **Medication-Specific Criteria** (Note: Check boxes under specific medication to attest that ***all*** criteria is met for that medication) |
| ***Psychostimulants***[ ]  Client is over the age of 16 and has been prescribed psychostimulants by a DMH prescriber (directly-operated or contracted site) continuously for at least one year prior to the request. | ***Anticraving medications (Acamprosate, Naltrexone ER, Varenicline, Buprenorphine)***[ ]  Client has substance use disorder with significant impairment. [ ]  Client is receiving ongoing substance abuse counseling. [ ]  Clinical record documents evidence of effectiveness after 3 months use. |
| ***Zolpidem (and other off-formulary insomnia medications)***[ ]  Client is not currently prescribed or receiving benzodiazepine.[ ]  Client does not have current substance use diagnosis.[ ]  If client is currently using requested medication, length of time from first prescription is less than six months. | ***Branded Antipsychotic Polypharmacy (Please note current and past medications in Rationale Section)***[ ]  Client/Medication not eligible for Indigent Medications Program.[ ]  Monotherapy or alternative polypharmacy (use of more than 1 branded antipsychotic) would cause significant adverse effects and/or poor outcomes.[ ]  Client had an unfavorable response to the current medication that requires an immediate switch.***Please indicate one:***[ ]  Switch[ ]  Ongoing Polypharmacy [ ]  Transfer of Care (e.g. hospital discharge) |

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| **Rationale (For any medication listed above, include additional information related to request.)****(For any medication not listed above, describe complete clinical rationale for request and attach additional documentation if necessary)**  ­­­­­­­­                  |

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| **Prescriber/Furnisher Information (*I hereby state that all of the indicated conditions pertain and the documented reasons for these conditions are accurate*.)** |
| Name:      | Signature: | Supervising Psychiatrist Name:\*\* | Signature: |
| DMH Site/Clinic Name:      | Phone #:      | **FAX # (REQUIRED):**      |

\* M-TARs received on Friday after 12 p.m. will be reviewed on the next business day.

\*\*Designees must include name of Supervising Psychiatrist and Designee name and signature. No Supervising Psychiatrist signature is required if the site is a DMH contracted provider.