Tennessee Department of Children's Services

Prior Authorization for Non-Preferred Medication

Child's Name_____ DOB_____

Electronic Record System #_____

Placement_____

Date of request_____

Diagnosis_____ ICD-10 Code_____

Current total drug regimen including dosing schedule_____

_____

_____

List all other medications previously tried, including dose, schedule and length of product use

_____

_____

_____

Provide detailed reason alternatives were discontinued or not utilized _____

_____

_____

Drug requested_____ Quantity_____

Dosage and frequency_____ Duration of need_____

Reason for use of Non-Preferred drug_____

_____

_____

_____

Physician/NP/PA name (print)_____

Signature_____ Phone_____

Please email form to EI_DCS.ChildHealth_CO_Fax@tn.gov

COE review date_____ Approved Yes_____ No_____

Reason for non-approval_____

Approval signature _____

Print name_____ Date_____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.

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