

Prior Authorization for Non-Preferred Medication (for exclusive use by YDC Clinic Staff)

| Student's Name: | DOB: | TFACTS ID #: | |
|--|---|----------------------------|----------------|
| YDC Placement: | | | |
| YDC Phone #: | Fax #: | | |
| Date of Request: | | | |
| Diagnosis: | | | |
| Drug Requested: | | Quantity: | |
| Dosage//Frequency: Length of therapy on prescription: | | | |
| Reason for use of Non-Preferred drug: | | | |
| Physician/NP/PA Name: | | | |
| Please email or fax this form Attention: Director of Nursin | to DCS Central Office, fax #615-741-7322 g | | |
| Medical Director: | | | |
| Name: | | Date: | |
| The Tennessee Preferred Dro | ug List is available via the web at https://w | ww.tn.gov/tenncare/topic/m | ember-pharmacy |

INSTRUCTIONS FOR USE OF FORM

This form is for exclusive use by YDC Clinic staff only.

This form is to be completed by clinic staff to secure authorization for Non-Preferred Medication



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

Distribution: Student Medical Record, Child and Adolescent Psychiatrist Consultant

CS-0854

Rev: 6/17

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RDA 2985