TN Department of Children's Services

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:

1. _____
2. _____
3. _____
4. _____

Physician/NP/PA Name: _____

Please email or fax this form to DCS Central Office, fax #615-741-7322
Attention: Director of Nursing

Medical Director: _____

Name: _____ **Date**: _____

The Tennessee Preferred Drug List is available via the web at https://www.tn.gov/tenncare/topic/member-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