



NEW AVENUES / MBHN:

Medication Management Review – Authorization Request

Employee Assistance Program • P.O. Box 360, South Bend, IN 46624 • Phone: (866) 925 - 5730 • Fax: (574) 271 – 5980
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<p style="text-align: center;">For Psychiatry Use Only When to submit this form:</p> <p style="text-align: center;">This form replaces the ICA & may be used to request Medication Mgmt Sessions – 90862 & 90805 only If requesting more than 8 sessions or other codes, i.e. 90807, please submit an OTR form</p>	<p>VI. DSM-IV Diagnosis:</p> <p>AXIS I: _____ Description: _____</p> <p>AXIS II: _____ Description: _____</p> <p>AXIS III: _____</p> <p>AXIS IV: _____</p> <p>AXIS V: (current GAF): _____ AXIS V: (past year GAF): _____</p>																																				
<p>I. Demographics: Client's Name: _____ DOB #: _____</p> <p>Address: _____ Case #: _____</p> <p>_____ City, St Zip: _____</p> <p>Home Phone: _____ Work Phone: _____</p>	<p>VII. Medication & Lab Tests:</p> <p>Compliant with Medication: <input type="checkbox"/> Yes <input type="checkbox"/> No PCP Name: _____</p> <p>List side effects (if any): _____ Current Release: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____ Notified PCP: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____ Date: _____</p>																																				
<p>III. Risk Assessment:</p> <p>Suicide Risk: <input type="checkbox"/> None <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High</p> <p>Within the Past 3 Months: <input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Attempt</p> <p>Date: _____ Describe: _____</p> <p>_____</p>	<p>All Medications (list in order by prescription date):</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;">Name of medication:</th> <th style="width:10%;">Dose:</th> <th style="width:10%;">Frequency:</th> <th style="width:10%;">Start Date:</th> <th style="width:10%;">End Date:</th> <th style="width:10%;">Prescribing MD:</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name of medication:	Dose:	Frequency:	Start Date:	End Date:	Prescribing MD:																														
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<p>Homicide Risk: <input type="checkbox"/> None <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High</p> <p>Within the Past 3 Months: <input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Attempt</p> <p>Date: _____ Describe: _____</p> <p>_____</p>	<p>XIII. Provider Coordination of Care with PCP:</p> <p><input type="checkbox"/> Patient has signed consent form <input type="checkbox"/> Patient declined to sign consent form</p> <p><input type="checkbox"/> Provider has not discussed consent form with Patient</p> <p>Communicated with PCP by: <input type="checkbox"/> Verbal <input type="checkbox"/> Written Date of communication with PCP: _____</p>																																				
<p>Physical Violence: <input type="checkbox"/> None <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High</p> <p>Within the Past 3 Months: <input type="checkbox"/> Ideation <input type="checkbox"/> Intent <input type="checkbox"/> Plan <input type="checkbox"/> Means <input type="checkbox"/> Attempt</p> <p>Date: _____ Describe: _____</p> <p>_____</p>	<p>VIII. Frequency & Duration of Care:</p> <p>First Appointment Date: _____ Last Appointment Date: _____</p> <p><input type="checkbox"/> ___ 90862 <input type="checkbox"/> ___ 90805 <input type="checkbox"/> ___ Other: _____</p> <p>Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually <input type="checkbox"/> Other, Explain: _____</p> <p>Number of Sessions Requesting for the next twelve (12) months: _____</p> <p>Date this authorization should begin: _____</p> <p>Provider's Name (Print): _____ Degree: _____</p> <p>Provider's Signature: _____ Date Signed: _____</p>																																				
<p>IV. Chemical Abuse/Dependency:</p> <p>Non-User/Abstainer <input type="checkbox"/> Yes <input type="checkbox"/> No Self Medication <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Experimental User <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of Control <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Social/Recreational User <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Describe: _____</p>	<p>V. Treatment History:</p> <table style="width:100%;"> <tr> <td style="width:50%; vertical-align: top;"> <p>Psychiatric:</p> <p>Inpatient <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Outpatient <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Med Management <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Substance/Chemical:</p> <p>Detox <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rehab <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Outpatient <input type="checkbox"/> Yes <input type="checkbox"/> No</p> </td> <td style="width:50%; vertical-align: top;"> <p>Discharge:</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> </td> </tr> </table>	<p>Psychiatric:</p> <p>Inpatient <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Outpatient <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Med Management <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Substance/Chemical:</p> <p>Detox <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rehab <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Outpatient <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Discharge:</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p> <p><input type="checkbox"/> <30 Days <input type="checkbox"/> <1 Year <input type="checkbox"/> >1 Year ago</p>																																		
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