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Prior Authorization Request Form for Antipsychotics in Children 5-17 Years Old

Requests for prior authorization (PA) must include member name, Medicaid ID #, drug name and appropriate clinical information to support the request on the basis of medical necessity. Please include all requested information. Incomplete forms will delay the PA process.

The completed form may be faxed to 1-844-490-4736.

All questions must be answered. Incomplete forms will delay the service authorization process.

Member information		
Name:		Medicaid ID # (12 digits):
Date of birth:	Gender: ☐ Male ☐ Female	Weight in kilograms:
Drug and medical information		
Drug name, dosage form and strength:		Administration schedule or dosing frequency:
Quantity requested:		Total daily dose:
Indicate the diagnoses being treated (include all ICD-10 codes if applicable):		
Is the prescribing provider a psychiatrist, neurologist or a developmental/behavioral pediatrician? ☐ Yes — Document the specialty: _____ ☐ No — Has the provider consulted with a psychiatrist, neurologist or a developmental/behavioral pediatrician before prescribing the requested medication? ☐ Yes — Date of consult: _____ ☐ No **(must be obtained within 90 days)**		
Has the patient received a developmentally appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented? ☐ Yes ☐ No If no, is one scheduled? ☐ Yes — Date psychiatric assessment scheduled: _____ ☐ No If no, check all reasons that apply: ☐ **Services not available in area.** ☐ **List other reason(s):**		

Has the patient in the last 12 months had at least one of the following:

- Tried nondrug treatment measures such as psychosocial intervention/care? ☐ Yes ☐ No
- Had an acute inpatient visit for schizophrenia, bipolar disorder or other psychotic disorder? ☐ Yes ☐ No
- Had at least two visits in outpatient, intensive outpatient or partial hospitalization settings for schizophrenia, bipolar disorder or other psychotic disorder? ☐ Yes ☐ No

List other antipsychotic agents tried and outcome:

1.

2.

For nonpsychiatric diagnoses only

Is this medication being prescribed to treat one of the following diagnoses when no therapeutic alternative exists or therapeutic alternatives were ineffective:

Nausea and vomiting ☐ Yes ☐ No

Tourette's disorder ☐ Yes ☐ No

Presurgical apprehension ☐Yes ☐No

List therapeutic alternatives tried and outcome:

If this request is denied or if more information is required, please list a phone number where you can be reached for a peer-to-peer consultation.

Prescriber information

Name (print): _____ NPI number: _____

Address: _____

Phone number: _____ Fax number: _____

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission or concealment of material may be subject to civil or criminal liability.

_____ _____

Prescriber's signature (or authorized representative) Date

Fax the completed form to 1-844-490-4736. Service authorization criteria is subject to change.