Atypical Antipsychotics for Children Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last)	(First)	(MI)	WV Medicaid 11-Digit ID #	Date of Birth (MM/DD/YYYY)

Prescriber Name (Last)	(First)	(MI)

Prescriber Address (Street)	(City)	(State)	(Zip)

Prescriber 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)

Provider Type/Specialty: ☐MD ☐DO ☐NP ☐PA Specialty:_____

Pharmacy Name (if applicable)			
Pharmacy Address (Street)	**(City)**	**(State)**	**(Zip)**

Pharmacy 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)

Confidentiality Notice: This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity named above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at (800) 847-3859 and arrange for the return or destruction of these documents.

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the member's medical condition or prior prescription history for drugs that require prior authorization.

Check one: ☐ Age < 6 years ☐ Age 6 years to < 18 years

Child under state care/custody: ☐ Yes ☐ No ☐ Foster Care ☐ Juvenile Services ☐ Past Medical Records Available

Medication Request: ☐ New ☐ Continuation Sex: ☐ Male ☐ Female Ht: Wt: BMI:

Antipsychotic Medication/Strength: Quantity:

Directions:

Target Symptoms: (check all that apply)
☐ Severe Aggression ☐ Self-Injurious Behavior ☐ Extreme Impulsivity ☐ Extreme Irritability
☐ Psychotic Symptoms ☐ Other (please specify): _____

Diagnosis:
☐ ADHD ☐ Autism/PDD ☐ Bipolar Disorder ☐ Disruptive Behavior Disorder ☐ ODD
☐ Schizoaffective Disorder ☐ Schizophrenia ☐ Other (please specify): _____

Functional Impairment: ☐ 1 (low) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (severe)

Psychiatrist Referral:
If the prescriber is NOT a psychiatrist, the patient:
☐ has been referred to psychiatrist
☐ will be referred to psychiatrist
☐ will not be referred to psychiatrist

Behavioral Therapy:
Is the patient receiving behavioral therapy? ☐ Yes ☐ No
If yes, please document how often the patient is going to therapy: _____
If no, will the patient be referred to behavioral therapy?
☐ Yes
☐ No (if no, why not?): _____

Intellectual Disability:
Does the patient have moderate to severe intellectual disability? ☐ Yes ☐ No

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Previous Therapy (pharmacological and non-pharmacological):

Current Therapy (pharmacological and non-pharmacological):

Have metabolic monitoring labs* (fasting lipids and glucose) been performed within the last six months? ☐ Yes ☐ No

** Official lab results (most recent) must be attached. For continuation therapy, labs are required.* Date: (MM/DD/YYYY)

Has an assessment for Tardive Dyskinesia* been done in the last six months? AIMS: ☐ Yes ☐ No DISCUS: ☐ Yes ☐ No

** Official form or notation (most recent) must be attached.* Date: (MM/DD/YYYY)

Next appointment date: (MM/DD/YYYY)

Other Pertinent Information (attach additional pages if necessary):

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature:

Date: (MM/DD/YYYY)

Required for Peer Review: Copies of medical records (diagnostic evaluation and recent chart notes), the original prescription and any related lab results. The provider must retain copies of all documentation for five years.

WV Medicaid Advisory Panel: ☐ Approval not Recommended ☐ Approval Recommended for _____ months

Date: (MM/DD/YYYY)