OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay the process.**

Drug Requested: Antipsychotic Medication in Children (0-17 years of Age)

Drug Name/Form/Strength: ______________________________

Administration Schedule: ______________________________

Quantity: ______________________ Total Daily Dose: ______________________

❒ **New Therapy** **OR** ❒ **Continuation Therapy**

Length of Authorization: 6 months

PRESCRIBER INFORMATION

Is the prescriber a Psychiatrist, Neurologist or a Developmental/Behavioral Pediatrician? ❒ Yes **OR** ❒ No
Indicate Specialty: ______________________________

If **No**, has the prescriber consulted with a Psychiatrist, Neurologist, or Developmental/Behavioral Pediatrician prior to prescribing the requested medication? ❒ Yes **OR** ❒ No

If **Yes**, Name: ______________________________

Specialty: ______________________ Date of Consult: ______________

DIAGNOSIS AND SYMPTOMS

ICD Diagnosis Code(s): ______________ Diagnosis Code Description(s):
____

Target Symptoms (check all that apply): ❑ Severe Aggression ❑ Extreme Irritability
❑ Extreme Impulsivity ❑ Self-Injurious Behavior ❑ Psychotic Symptoms
❑ Other: ______________________________

MEDICAL/CLINICAL INFORMATION

Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented? ❒ Yes **OR** ❒ No

If No, is one scheduled? ❒ Yes **OR** ❒ No

- **If Yes**, date psychiatric assessment is scheduled: ______________________
- **If No,** check all reasons that apply: ❑ Services not available in area ❑ List Other reason: ______________________________

Psychosocial treatment is in place without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy? ❒ Yes **OR** ❒ No

Name of program: ______________________ Enrolled in program on: ______________

If assistance is needed locating a provider, please contact Optima Health's Member Services Department.

Has informed consent for this medication been obtained from parent or guardian? ❒ Yes **OR** ❒ No

Has a family assessment been performed (including parental psychopathology and treatment needed) and have family functioning and parent-child relationship been evaluated? ❒ Yes **OR** ❒ No

Current/Past Therapy

Current Therapy: (pharmacological and non-pharmacological)

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Previous Therapy: (include Outcomes, pharmacological and non-pharmacological)

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If the drug requested is: Abilify®, aripiprazole ODT, Clozaril®, Fanapt®, FazaClo®, Geodon®, Invega®, olanzapine IM, paliperidone ER, Rexulti®, Risperdal®, Saphris® SL, Seroquel®, Seroquel XR®. Symbyax®, Versacloz®, Vraylar®, Zyprexa®, the following criteria **MUST** be met:

❑ Patient has tried and failed **at least 30 days** of therapy with **two (2)** of the following**:**

❑ aripiprazole solution/tablets	❑ clozapine tablets	❑ Geodon® IM
❑ Latuda®	❑ olanzapine ODT/tablets	❑ olanzapine/fluoxetine
❑ quetiapine tablets	❑ quetiapine fumerte ER	❑ risperidone ODT/soln/tab
❑ ziprasidone capsules		

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: ______________________________

Member Optima #: ____________________ Date of Birth: ______________

Prescriber Name: ______________________________

Prescriber Signature: ____________________ Date: ______________

Office Contact Name: ______________________________

Phone Number: ____________________ Fax Number: ______________

DEA OR NPI #: ______________________________

REVISED/UPDATED: ~~6/30/2017; 8/9/2017; 2/26/2018; 2/28/2018;~~ **8/16/2018**