OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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) - *MEDICAID*

Drug Name:	**Dosage Form/Strength**:	**Quantity**:
Administration Schedule: _____ _____ _____	Total Daily Dose: _____ _____	❒ New Therapy **OR** ❒ Continuation Therapy

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

Current Height:	Current Weight:	Current BMI:	Date of Ht/Wt/BMI:
_____ inches	_____ lbs.	_____	_____

Has the required baseline/follow-up monitoring* of the following been completed? ***(*current labs, within 12 months, must be attached for approval)*** ❒ Yes **or** ❒ No

- ❒ Blood Pressure: _____
- ❒ Fasting Lipid Panel
- ❒ Fasting Glucose and/or Hemoglobin A1c (HbA1c)

Has an assessment* for Tardive Dyskinesia been done in the last 12 months? (❒ DISCUS **OR** ❒ AIMS)
(*assessment must be attached for approval) ❒ Yes **or** ❒ No

Next appointment date: _____

(continued on next page)

CURRENT/PAST THERAPY

Behavioral/Psychosocial treatment is in place without adequate clinical response and will continue for the duration of medication therapy? ❒ Yes **or** ❒ No

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

Current Therapy: *(pharmacological and non-pharmacological)*

_____

_____

_____

Previous Therapy: *(pharmacological and non-pharmacological)*

_____

_____

_____

***If the drug requested is*: Abilify, Invega, Saphris or Seroquel XR, the following criteria *must* be met:**

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

***Length of Authorization*:** **12 months**

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**;