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

***Length of Authorization*: 12 months // for members < 18 yrs 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):
_____ _____	_____ _____

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

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

PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

Name of program: _____ Enrolled in program on: _____

If this request is denied or if more information is required, please list a phone number where prescriber can be reached for a peer-to-peer consultation with the program's Board Certified Pediatric Psychiatrist.

Print Prescriber's First and Last Name: _____

Phone Number: _____

(continued on next page)

List pharmaceutical agents attempted and outcome:

1. _____
2. _____
3. _____

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**