

OPTIMA HEALTH PLAN

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 authorization process.**

Drug Requested: Antipsychotic Medication in Children (0-17 years of Age)
FAMIS/SENTARA FAMILY CARE (SFC-MEDICAID)

Drug Name:	Dosage Form/Strength:	Quantity:
Administration Schedule:	Total Daily Dose:	<input type="checkbox"/> New Therapy <b style="text-align: center;">OR <input type="checkbox"/> Continuation Therapy

Length of Authorization: 12 months

Prescriber Information	
Is the prescriber a Psychiatrist, Neurologist or a Developmental/Behavioral Pediatrician?	
Indicate Specialty: _____ <input type="checkbox"/> Yes OR <input type="checkbox"/> No	
If No , has the prescriber consulted with a Psychiatrist, Neurologist, or Developmental/Behavioral Pediatrician prior to prescribing the requested medication? <input type="checkbox"/> Yes OR <input type="checkbox"/> No	
If Yes , Name: _____ Specialty: _____	
Date of Consult: _____	
Diagnosis and Symptoms	
ICD Diagnosis Code(s):	Diagnosis Code Description(s):
<u>Target Symptoms: (check all that apply)</u> <input type="checkbox"/> Severe Aggression <input type="checkbox"/> Extreme Irritability <input type="checkbox"/> Extreme Impulsivity <input type="checkbox"/> Self-Injurious Behavior <input type="checkbox"/> Psychotic Symptoms <input type="checkbox"/> 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? <input type="checkbox"/> Yes OR <input type="checkbox"/> No	
If No , is one scheduled? <input type="checkbox"/> Yes OR <input type="checkbox"/> No	
<ul style="list-style-type: none"> • If Yes, date psychiatric assessment is scheduled: _____ • If No, check all reasons that apply: <input type="checkbox"/> Services not available in area <input type="checkbox"/> 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? <input type="checkbox"/> Yes OR <input type="checkbox"/> No	

(continued on next page)

PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

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 needs) and have family functioning and parent-child relationship been evaluated? Yes **OR** No

Current/Past Therapy

Current Therapy: (pharmacological and non-pharmacological)

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

If the drug requested is: Latuda, 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:

<input type="checkbox"/> risperidone	<input type="checkbox"/> quetiapine	<input type="checkbox"/> aripiprazole
<input type="checkbox"/> ziprasidone	<input type="checkbox"/> olanzapine	

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 #: _____

*Approved by Pharmacy and Therapeutics Committee: 11/27/2016

REVISED/UPDATED: 12/9/2016; 1/20/2017; 1/27/2017; 8/9/2017; 9/29/2017; 5/30/2018; 8/8/2018; 9/28/2018;