

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) - MEDICAID

Drug Name:	Dosage Form/Strength:	Quantity:
Administration Schedule:	Total Daily Dose:	<input type="checkbox"/> New Therapy 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: _____ Yes **or** No

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

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: _____

Current/Past Therapy

*Behavioral/Psychosocial treatment is in place without adequate clinical response and will continue Yes **or** No for the duration of medication therapy?
If assistance is needed locating a provider, please contact Optima Health's Member Services Department.

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

(continued on next page)

Current Therapy: <i>(pharmacological and non-pharmacological)</i>		
Previous Therapy: <i>(pharmacological and non-pharmacological)</i>		
<u>If the drug requested is:</u> Latuda, Invega, Saphris or Seroquel XR, the following criteria <u>must</u> be met:		
<input type="checkbox"/> Patient has tried and failed <u>at least 30 days</u> of therapy with <u>two (2)</u> 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**