



MANUAL MEDICATION PRIOR AUTHORIZATION REQUEST FORM



Multiple Antipsychotics for Patients Less Than Age 18 Years (Typical and Atypical Antipsychotics, Preferred and Non-Preferred Medications)

Beneficiary ID#: _____ Beneficiary Full Name: _____

Gender: Male Female Age: _____

Beneficiary under State Care/Custody: Yes No Unknown

Medication Request: New Continuation

Diagnosis: (check all that apply)

- ADHD Disruptive Behavior Disorder Schizoaffective Disorder Autism Spectrum
 Disruptive Mood Dysregulation Disorder Schizophrenia Bipolar Disorder Tourette's
Other: _____

Height: _____ in. OR _____ cm. Weight: _____ lb. OR _____ kg. BMI: _____

Target Symptoms: (check all that apply) Aggression Impulsivity Irritability
Mood Instability: Depressed Manic Psychosis Self-Injurious Behavior Other: _____

Overall Target Symptoms Severity: 1-Mild 2-Moderate 3-Severe

Functional Impairment: 1-Mild 2-Moderate 3-Severe

List All Current Medications: _____

Table with 4 columns: Antipsychotic Requested, Strength, Directions, Quantity. Contains 3 empty rows.

Yes No NA If prescribing more than one (1) antipsychotic, is the plan to cross taper, with antipsychotic dual/monotherapy resumed within the next ninety (90) days? (if applicable)
IF YES: Which of the medication(s) listed above will be discontinued? _____

IF NO: What is the rationale for continuing treatment with two (2) or more antipsychotics? _____

Yes No Beneficiary has chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies, such as, but not limited to, evidence based behavioral, cognitive, and family based therapies.

Yes No Beneficiary is currently receiving non-pharmacologic/psychosocial services.

Yes No For a beneficiary not currently receiving non-pharmacologic/psychosocial services, a referral has been made and an appointment is pending. If there is no pending appointment, provide explanation below: _____

Has an assessment for Extrapyramidal Symptoms, including Tardive Dyskinesia (TD) been done in the last 26 weeks (6 months)? AIMS: Yes No OR DISCUS: Yes No AIMS/DISCUS Forms

Yes No Medical record documentation of metabolic monitoring: weight or BMI, blood pressure, fasting glucose, and a fasting lipid panel within the last 12 months.

Next appointment date: _____

I certify that the benefits of antipsychotic treatment outweigh the risks of treatment.

Prescriber's Signature: _____ Specialty: _____