MANUAL MEDICATION PRIOR AUTHORIZATION
REQUEST FORM

Multiple Antipsychotics for Patients Under the age of 18 years (Typical and Atypical Antipsychotics, Preferred and Non-Preferred Medications) 10/01/2016

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>
<thead>
<tr>
<th>Antipsychotic Requested</th>
<th>Strength</th>
<th>Directions</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ 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: ____________________________