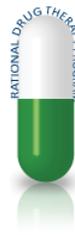


Atypical Antipsychotics for Children Prior Authorization Form



West Virginia Medicaid
 Drug Prior Authorization Form
<http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx>

Rational Drug Therapy Program
 WVU School of Pharmacy
 PO Box 9511 HSCN
 Morgantown, WV 26506
 Fax: 1-800-531-7787
 Phone: 1-800-847-3859



Patient Name (Last)	(First)	(MI)	WV Medicaid 11-Digit ID #	Date of Birth (MM/DD/YYYY)
---------------------	---------	------	---------------------------	----------------------------

Prescriber Name (Last)	(First)	(MI)		
------------------------	---------	------	--	--

Prescriber Address (Street)	(City)	(State)	(Zip)
-----------------------------	--------	---------	-------

Prescriber 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)
---------------------------	------------------------	----------------------

Provider Type/Specialty: MD DO NP PA Specialty: _____

Pharmacy Name (if applicable) _____

Pharmacy Address (Street)	(City)	(State)	(Zip)
---------------------------	--------	---------	-------

Pharmacy 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)
-------------------------	------------------------	----------------------

Confidentiality Notice: This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity named above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately by telephone at (800) 847-3859 and arrange for the return or destruction of these documents. Thank you.

Important Notes: Preauthorization for medical necessity does not guarantee payment.
 The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Check one: Age < 6 years Age 6 years to < 18 years

Child under state care/custody: Yes No Foster Care Juvenile Services Past Medical Records Available

Medication Request: New Continuation Patient: Male Female Ht: Wt: BMI:

Antipsychotic Medication/Strength: _____ Quantity: _____

Directions: _____

Target Symptoms: Severe Aggression Self-Injurious Behavior Extreme Impulsivity Extreme Irritability
 (check all that apply) Psychotic Symptoms Other: _____

Diagnosis: ADHD Autism/PDD Schizophrenia Schizoaffective d/o ODD
 Disruptive Behavior d/o Bipolar Disorder Other: _____ ICD Code: _____

Functional Impairment: 1 (low) 2 3 4 5 (severe)

If the prescriber is NOT a psychiatrist, the patient
 has been referred to psychiatrist
 will be referred to psychiatrist
 will not be referred to psychiatrist

If the patient is undergoing behavioral therapy, please document how often the patient is going to therapy _____

If not, will the patient be referred to behavioral therapy
 Yes
 No (if no, why not?) _____

Does the patient have moderate to severe intellectual disability?: _____

Atypical Antipsychotics for Children Prior Authorization Form

Previous Therapy (Pharmacological and Non-Pharmacological):

Current Therapy (Pharmacological and Non-Pharmacological):

Have metabolic monitoring labs* (fasting lipids and glucose) been performed within the last 6 months? Yes No

* Official lab results (most recent) must be attached. For continuation therapy, labs are required.

Date:
(MM/DD/YYYY)

Has an assessment for Tardive Dyskinesia been done in the last 6 months? AIMS: Yes No DISCUS: Yes No

* Official form or notation (most recent) must be attached.

Date:
(MM/DD/YYYY)

Next appointment date:
(MM/DD/YYYY)

Other Pertinent Information (attach additional pages)

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

Check here for electronic signature

Prescriber or Pharmacist Signature:

Date: (MM/DD/YYYY)

Required for Peer Review: Copies of medical records (diagnostic evaluation & recent chart notes), the original prescription and any related lab results. The provider must retain copies of all documentation for five years.

WV Medicaid Advisory Panel: Approval not Recommended Approval Recommended for _____ months

Date:
(MM/DD/YYYY)