AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – A+KIDS: Antipsychotics-Keeping it Documented for Safety

Beneficiaries 17 Years of Age and Younger

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days
12. Dose instructions: _____

Clinical Information

For Non-preferred Medications:

1. __ Failed 1 preferred drug? Yes___ No___ List preferred drugs failed: _____
1a. __ Allergic Reaction 1b. __ Drug-to-drug Interaction Please describe reaction: _____
2. __ Previous episode of unacceptable side effect or therapeutic failure. Please provide clinical information: _____
_____
3. __ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provide clinical information: _____
4. __ Age specific indications. Please give patient age and explain: _____
5. __ Unique clinical indication supported by FDA approval or peer reviewed literature.
Please explain and provide a general reference: _____
6. __ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Criteria for ALL medications:

7. What is the beneficiary's Primary Psychiatric diagnosis? ☐ Attention Deficit-Hyperactivity Disorder ☐ Bipolar Disorder
☐ Disruptive Behavior Disorder ☐ Mood Disorder-NOS ☐ Any Pervasive Development Disorder ☐ PTSD
☐ Schizoaffective Disorder ☐ Schizophrenia ☐ Tourette's Syndrome ☐ Other: _____
8. What is the beneficiary's target symptom? ☐ Aggression ☐ Impulsivity ☐ Inattentiveness ☐ Irritability
☐ Mania ☐ Oppositional ☐ Psychosis ☐ Other: _____
9. Measurements: Obtained baseline BMI? Yes___ No___
BMI measured at regular intervals? Yes___ No___
10. Labs: Obtained at baseline and monitored at regular intervals: Lipid Profile? Yes___ No___ Glucose Level? Yes___ No___
Fasting Glucose Monitored? Yes___ No___
10a. If labs were not completed select one of the following reasons: ☐ Pending ☐ Not clinically indicated ☐ Unable to obtain
11. Has the beneficiary had clinical improvement since starting the Drug Treatment? Please select most appropriate:
☐ Modestly improved ☐ Much improved ☐ Very much improved ☐ No change ☐ Not accessed/Not applicable
☐ Modestly worse ☐ Much worse ☐ Very much worse
12. Adverse effects over the past week:

Daytime Sedation:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Significant restlessness:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Stiffness/Dystonia/Tremor:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Other Dyskinesia:	☐ Mild	☐ Moderate	☐ Severe	☐ None

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406