# 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; **(Pharmacy) 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

## Drug Requested: Antipsychotic Medication in Children (0-17 years of Age)

| Drug Name: | Dosage Form/Strength: | Quantity: |
|---|---|---|
| Administration Schedule: | Total Daily Dose: | ❒ New Therapy<br>**OR**<br>❒ Continuation Therapy |

### 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

Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented? ❒ Yes **OR** ❒ No

**If No,** is one scheduled? ❒ Yes **OR** ❒ No

- **If Yes**, date psychiatric assessment is scheduled: _____
- **If No,** check all reasons that apply: ❑ Services not available in area ❑ List Other reason _____

Psychosocial treatment is in place without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy? ❒ Yes **OR** ❒ No

**(continued on next page)**

## PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

Name of program: _____

Enrolled in program on: _____

***If assistance is needed locating a provider, please contact Optima Health's Member Services Department.***

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

Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated? ❒ Yes **OR** ❒ No

## Current/Past Therapy

**Current Therapy:** (pharmacological and non-pharmacological)

_____

_____

**Previous Therapy:** (Include Outcomes, pharmacological and non-pharmacological)

_____

_____

_____

**If the drug requested is: Caplyta®, Fanapt®, paliperidone (Invega®), Rexulti®, Saphris®, or Vraylar®, the following criteria must be met:**

❑ Patient has tried and failed at least **30 days** of therapy with **two (2)** of the following:

| | | |
|---|---|---|
| ❑ risperidone | ❑ quetiapine/XR | ❑ aripiprazole |
| ❑ ziprasidone | ❑ olanzapine | |

***Not all drugs may be covered under every Plan***

***If a drug is non-formulary on a Plan, documentation of medical necessity will be required.***

****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; 8/8/2018; 9/28/2018; 1/7/2019;~~ 5/10/2019; **12/7/2020**