SENTARA COMMUNITY PLAN
(MEDICAID)

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; **fax to 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)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

❑ **New Therapy** **OR** ❑ **Continuation Therapy**

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

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: 6 months

- **Does the member meet the following criteria?**

(Continued on next page)

PRESCRIBER INFORMATION

1. Is provider a Psychiatrist, Neurologist or a Developmental/Behavioral Pediatrician? ❑ **Yes** ❑ **No**

If **YES**, indicate Specialty: _____

If **NO**, has provider consulted with a Psychiatrist, Neurologist, or Developmental/Behavioral Pediatrician prior to prescribing the requested medication? ❑ **Yes** ❑ **No**

If **YES**, date of consult: _____

MEDICAL/CLINICAL INFORMATION

2. Has member received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented? ❑ **Yes** ❑ **No**

If **NO,** is one scheduled? ❑ **Yes** ❑ **No**

If **YES**, date psychiatric assessment is scheduled: _____

If **NO,** check below **all** reasons that apply.

❑ Services not available in area ❑ List other reason: _____

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

4. Has informed consent for this medication been obtained from parent or guardian? ❑ **Yes** ❑ **No**

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

MEMBER'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

Name of program:

Enrolled in program on:

List pharmaceutical drugs attempted and outcome:

_____

_____

_____

_____

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.

REVISED/REFORMATTED/UPDATED: ~~6/30/2017; 8/9/2017; 2/26/2018; 2/28/2018; 8/16/2018; 9/28/2018;~~ 6/25/2019; 9/7/2019; 09/09/2022; 11/8/2023; 04/22/2024; **9/10/2025**