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:** ____________________

DEA OR NPI #: ______________________________

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: ______________________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________

Diagnosis: ____________________ **ICD Code, if applicable:** ____________

Weight: ____________________ **Date:** ____________________

❑ **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?**

DIAGNOSIS AND SYMPTOMS

Target Symptoms (check all that apply): ❑ Severe Aggression ❑ Extreme Irritability

❑ Extreme Impulsivity ❑ Self-Injurious Behavior ❑ Psychotic Symptoms

❑ Other: ______________________________

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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; 9/7/201909/09/20/2022; 11/8/2023~~; **04/22/2024**