SENTARA HEALTH PLANS

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 Name:	Dosage Form/Strength:	Quantity:
Administration Schedule:	Total Daily Dose:	❒ New Therapy **OR** ❒ 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: _____

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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

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)

_____

_____

_____

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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.****