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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

ANTIPSYCHOTICS IN CHILDREN YOUNGER THAN 18 YEARS OLD

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name: _____

First Name: _____

Medicaid ID Number: _____

Date of Birth: _____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name: _____

First Name: _____

NPI Number: _____

Phone Number: _____

Fax Number: _____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

DIAGNOSIS AND MEDICAL INFORMATION

Antipsychotics in Children Younger than 18 Years Old – to receive an approval for this drug, complete the following questions.

Indicate the Diagnoses Being Treated (Include ALL ICD Codes if Applicable):

Does the patient meet the following criteria?

1. **Is the prescribing provider a Psychiatrist, Neurologist, or a Developmental/Behavioral Pediatrician?**
   ☐ Yes ☐ No
   If yes, document the specialty: _____
   If no, has the provider consulted with a Psychiatrist, Neurologist, or a Developmental/Behavioral Pediatrician before prescribing the requested medication?
   ☐ Yes ☐ No
   If yes, date of consult: _____
2. **Has the patient 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 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 the 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

(Form continued on next page.)

Member's Last Name: **Member's First Name:**

PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

Name of Program:

Enrolled in Program on:

List pharmaceutical agents attempted and outcome:

If this request is denied or if more information is required, please list a phone number where you can be reached for a peer-to-peer consultation with the program's Board Certified Pediatric Psychiatrist.

Phone Number:

Last Name: **First Name:**

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Prime Therapeutics Management, LLC/Attn: GV – 4201
P.O. Box 64811, St. Paul, MN 55164-0811