

NC Medicaid
Prior Authorization Form
A+KIDS: Antipsychotics – Keeping it Documented for Safety
Beneficiaries 17 Years of Age and Younger
Fax this form to 858-790-7100

REQUESTER INFORMATION

Requester Last Name: _____

Requester First Name: _____

Requester Phone: _____ Requester Fax: _____ Date: _____

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Beneficiary ID: _____ Date of Birth: _____ Beneficiary Phone: _____

Sex: ☐ Male ☐ Female

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Prescriber NPI: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

Drug Form: _____ Dosing Frequency: _____

Quantity: _____ Length of Therapy: _____

Dose Instructions: _____

Beneficiary's Full Name: _____

CLINICAL INFORMATION

FOR NON-PREFERRED MEDICATIONS

1. Has the beneficiary failed **one** preferred drug?

☐ Yes ☐ No

If **YES**, answer the following questions:

List preferred drug(s) failed: _____

Describe reaction to drug: _____

2. Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:

3. Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information:

4. Age specific indications. Please give patient age and explain:

5. Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:

6. Unacceptable clinical risk associated with therapeutic change. Please explain:

CRITERIA FOR ALL MEDICATIONS

7. What is the beneficiary's Primary Psychiatric diagnosis?

☐ Attention Deficit-Hyperactivity Disorder

☐ Bipolar Disorder

☐ Disruptive Behavior Disorder

☐ Mood Disorder-NOS

☐ Any Pervasive Development Disorder

☐ PTSD

☐ Schizophrenia

☐ Schizoaffective Disorder

☐ Tourette's Syndrome

☐ Other: _____

8. What is the beneficiary's target symptom?

☐ Aggression

☐ Impulsivity

☐ Inattentiveness

☐ Irritability

☐ Mania

☐ Oppositional

☐ Psychosis

☐ Other: _____

9. Measurements obtained at baseline BMI?

☐ Yes ☐ No

Beneficiary's Full Name: _____

10. BMI measured at regular intervals?

☐ Yes ☐ No

11. Labs obtained at baseline and monitored at regular intervals:

a. Lipid Profile:

☐ Yes ☐ No

b. Glucose Level:

☐ Yes ☐ No

c. Fasting Glucose Monitored:

☐ Yes ☐ No

d. If labs were not completed select one of the following reasons:

☐ Pending ☐ Not clinically indicated ☐ Unable to obtain

12. Has the beneficiary had clinical improvement since starting the Drug Treatment? Please select most appropriate:

☐ Modestly improved

☐ Much improved

☐ Very much improved

☐ No change

☐ Not accessed/Not applicable

☐ Modestly worse

☐ Much worse

☐ Very much worse

13. Adverse effects over the past week:

Daytime Sedation: ☐ Mild ☐ Moderate ☐ Severe ☐ None

Significant Restlessness: ☐ Mild ☐ Moderate ☐ Severe ☐ None

Stiffness/Dystonia/Tremor: ☐ Mild ☐ Moderate ☐ Severe ☐ None

Other Dyskinesia: ☐ Mild ☐ Moderate ☐ Severe ☐ None

☐ Attachments

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of his/her knowledge.

Prescriber Signature: _____ **Date:** _____

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