



**NC Medicaid  
Prior Authorization Form  
A+KIDS: Antipsychotics – Keeping it Documented for Safety  
Beneficiaries 17 Years of Age and Younger  
Fax this form to 866-422-8981**

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**REQUESTER INFORMATION**

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Requester Last Name: \_\_\_\_\_

Requester First Name: \_\_\_\_\_

Requester Phone: \_\_\_\_\_ Requester Fax: \_\_\_\_\_ Date: \_\_\_\_\_

**BENEFICIARY INFORMATION**

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Beneficiary Last Name: \_\_\_\_\_

Beneficiary First Name: \_\_\_\_\_

Beneficiary ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Beneficiary Phone: \_\_\_\_\_

Sex:  Male  Female

**PRESCRIBER INFORMATION**

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Prescriber Last Name: \_\_\_\_\_

Prescriber First Name: \_\_\_\_\_

Specialty: \_\_\_\_\_ Prescriber NPI: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_ Prescriber Fax: \_\_\_\_\_

**DRUG INFORMATION**

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Drug Name: \_\_\_\_\_ Drug Strength: \_\_\_\_\_

Drug Form: \_\_\_\_\_ Dosing Frequency: \_\_\_\_\_

Quantity: \_\_\_\_\_ Length of Therapy: \_\_\_\_\_

Dose Instructions: \_\_\_\_\_

Beneficiary's Full Name: \_\_\_\_\_

## CLINICAL INFORMATION

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### 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

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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:** \_\_\_\_\_

Mail requests to:

Prime Therapeutics Management Prior Authorization Program

Attn: GV - 4201

P.O. Box 64811

St. Paul, MN 55164-0811

Phone: 844-620-6116

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