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

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: ______________________________

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Beneficiary’s Full Name: ____

CLINICAL INFORMATION

FOR NON-PREFFERED 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
   ☐ Disruptive Behavior Disorder
   ☐ Any Pervasive Development Disorder
   ☐ Schizophrenia
   ☐ Tourette’s Syndrome
   ☐ Bipolar Disorder
   ☐ Mood Disorder-NOS
   ☐ PTSD
   ☐ Schizoaffective Disorder
   ☐ Other: ______________________

8. What is the beneficiary’s target symptom?

   ☐ Aggression
   ☐ Inattentiveness
   ☐ Mania
   ☐ Psychosis
   ☐ Impulsivity
   ☐ Irritability
   ☐ Oppositional
   ☐ 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:** ______________

Mail requests to:

Magellan Rx Management Prior Authorization Program
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 844-620-6116

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