



Department of Vermont Health Access
312 Hurricane Lane, Suite 201
Williston, Vermont 05495

ANTIPSYC.2
FORM#01
R: 1.15

Agency of Human Services

~Antipsychotic Medications (Pediatric) (Age <18 Years Old)~ Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Beneficiary:

Name: _____
Physician NPI: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Pharmacy Name _____
Pharmacy NPI: _____
Pharmacy Phone: _____ Pharmacy Fax: _____

The following target symptoms or diagnoses for which the requested medication is being prescribed are documented in the patient chart:

YES NO Please check all that apply:

Target Symptom	Diagnosis
<input type="checkbox"/> Grandiosity/euphoria/mania <input type="checkbox"/> Obsessions/compulsions <input type="checkbox"/> Psychotic symptoms <input type="checkbox"/> Tics (motor or vocal) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Autism with Aggression and/or Irritability <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Intellectual Disability with Aggression and/or Irritability <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Tourette's Syndrome <input type="checkbox"/> Schizophrenia/Schizoaffective Disorder <input type="checkbox"/> Other: _____

1. Drug Requested: check below Strength, Route & Frequency: _____ Dosage Form: _____

Preferred After Clinical Criteria Are Met	Non-Preferred
<input type="checkbox"/> RISPERIDONE (compare to Risperdal®) <input type="checkbox"/> QUETIAPINE (compare to Seroquel®) <input type="checkbox"/> ZIPRASIDONE (compare to Geodon®) <input type="checkbox"/> OLANZAPINE (compare to Zyprexa®)	<input type="checkbox"/> Abilify® (aripiprazole) <input type="checkbox"/> Risperdal®(risperidone) <input type="checkbox"/> Clozaril® (clozapine) <input type="checkbox"/> Seroquel® (quetiapine) <input type="checkbox"/> Clozapine® (compare to Clozaril®) <input type="checkbox"/> Seroquel XR®(quetiapine XR) <input type="checkbox"/> Geodon® (ziprasidone) <input type="checkbox"/> Zyprexa® (olanzapine) <input type="checkbox"/> Invega® (paliperidone)

2. Please list preferred medications previously tried and failed for this condition:

Name of medication	Reason for failure	Date
_____	_____	_____
_____	_____	_____

3. Was patient seen by any other provider for this condition? YES NO

Who? _____ What specialty? _____

4. Please include any other pertinent information that supports this request (suggest attach chart notes) :

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature: _____ **Date of request:** _____

