

~ **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 telephone or complete and fax this form to Catamaran. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-866-767-2649 or Phone: 1-800-918-7549

Prescribing physician:

Beneficiary:

Name: _____

Name: _____

Phone #: _____

Medicaid ID #: _____

Fax #: _____

Date of Birth: _____ Sex: _____

Address: _____

Contact Person at Office: _____

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"/> Autism with Aggression and/or Irritability <input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Obsessions/compulsions	<input type="checkbox"/> Intellectual Disability with Aggression and/or Irritability
<input type="checkbox"/> Psychotic symptoms	<input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Tourette's Syndrome
<input type="checkbox"/> Tics (motor or vocal)	<input type="checkbox"/> Schizophrenia/ Schizoaffective Disorder
<input type="checkbox"/> Other: _____	<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"/> Abilify® (aripiprazole) <input type="checkbox"/> Olanzapine† (compare to Zyprexa®)
<input type="checkbox"/> QUETIAPINE† (compare to Seroquel®)	<input type="checkbox"/> Clozapine† (compare to Clozaril®) <input type="checkbox"/> Risperdal® (risperidone)
<input type="checkbox"/> ZIPRASIDONE† (compare to Geodon®)	<input type="checkbox"/> Clozaril® (clozapine) <input type="checkbox"/> Seroquel® (quetiapine)
<input type="checkbox"/> ZYPREXA® (olanzapine)	<input type="checkbox"/> Geodon® (ziprasidone) <input type="checkbox"/> Seroquel XR® (quetiapine XR)
	<input type="checkbox"/> Invega® (paliperidone)

Key: † Generic product

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):

Prescriber Signature: _____

Date of this request: _____