



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

ANTIPSYC.1  
FORM#01  
C: 12.14

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 telephone or 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: \_\_\_\_\_

Name: \_\_\_\_\_

Phone#: \_\_\_\_\_

Medicaid ID#: \_\_\_\_\_

Fax#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Contact Person at Office: \_\_\_\_\_

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
Grandiosity/euphoria/mania Obsessions/compulsions Psychotic symptoms Tics (motor or vocal) Other: _____	Autism with Aggression and/or Irritability    Bipolar Disorder Intellectual Disability with Aggression and/or Irritability Obsessive Compulsive Disorder    Tourette's Syndrome Schizophrenia/Schizoaffective Disorder Other: _____

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

Preferred After Clinical Criteria Are Met	Non-Preferred
RISPERIDONE (compare to Risperdal®) QUETIAPINE (compare to Seroquel®) ZIPRASIDONE (compare to Geodon®) OLANZAPINE (compare to Zyprexa®)	Abilify® (aripiprazole)    Risperdal®(risperidone) Clozaril® (clozapine)    Seroquel® (quetiapine) Clozapine® (compare to Clozaril®)    Seroquel XR®(quetiapine XR) Geodon® (ziprasidone)    Zyprexa® (olanzapine) 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:** \_\_\_\_\_

