VERMONT

Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

ANTIPSYC.3
FORM#01
R: 03.16

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. For questions, please contact the GHS Helpdesk at 1-844-679-5363.

Submit request via: Fax: 1-844-679-5366

Prescribing physician:

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

Beneficiary:

Name: _____
Medicaid ID#:_____
Date of Birth: _____ **Sex:** _____
Pharmacy Name_____
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	☐ Autism with Aggression and/or Irritability ☐ Bipolar Disorder
☐ Obsessions/compulsions	☐ Intellectual Disability with Aggression and/or Irritability
☐ Psychotic symptoms	☐ Obsessive Compulsive Disorder ☐ Tourette's Syndrome
☐ Tics (motor or vocal)	☐ Schizophrenia/Schizoaffective Disorder
☐ Other:_____	☐ Other: _____

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

Preferred After Clinical Criteria Are Met	Non-Preferred	
☐ RISPERIDONE (compare to Risperdal®)	☐ Abilify® (aripiprazole)	☐ Risperdal®(risperidone)
☐ QUETIAPINE (compare to Seroquel®)	☐ Aripiprazole (compare to Abilify®)	☐ Saphris®(asenapine)
☐ ZIPRASIDONE (compare to Geodon®)	☐ Clozaril® (clozapine)	☐ Seroquel® (quetiapine)
☐ OLANZAPINE (compare to Zyprexa®)	☐ Clozapine® (compare to Clozaril®)	☐ Seroquel XR®(quetiapine XR)
	☐ Geodon® (ziprasidone)	☐ Zyprexa® (olanzapine)
	☐ Invega® (paliperidone)	☐ Other_____

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:**_____

GHS
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