VERMONT

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

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

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. 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 Change Healthcare helpdesk at 1-844-679-5363.

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

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

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

1. The following target symptoms or diagnoses for which the requested medication is being prescribed (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 ☐ Disruptive Mood Dysregulation Disorder ☐ Major Depressive Disorder with Psychotic Features ☐ Other: _____

2. Drug Requested (check below): Strength, Dosage Form, Route & Frequency:_____

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

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

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

4. Has the patient received a comprehensive evaluation including non-pharmacological therapies (behavioral, cognitive, family based)?
_____
5. Does the patient have any preexisting medical conditions such as obesity or diabetes? _____
6. 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:_____

CHANGE HEALTHCARE