



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

Beneficiary:
 Name: _____
 Medicaid ID#: _____
 Date of Birth: _____ Sex: _____
 Pharmacy Name _____
 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
<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"/> Disruptive Mood Dysregulation Disorder <input type="checkbox"/> Major Depressive Disorder with Psychotic Features <input type="checkbox"/> Other: _____

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

Preferred After Clinical Criteria Are Met	Non-Preferred
<input type="checkbox"/> ARIPIPRAZOLE (compare to Abilify®) <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"/> Saphris®(asenapine) <input type="checkbox"/> Clozapine® (compare to Clozaril®) <input type="checkbox"/> Seroquel® (quetiapine) <input type="checkbox"/> Geodon® (ziprasidone) <input type="checkbox"/> Seroquel XR®(quetiapine XR) <input type="checkbox"/> Invega® (paliperidone) <input type="checkbox"/> Zyprexa® (olanzapine) <input type="checkbox"/> Latuda® (lurasidone) <input type="checkbox"/> Other _____

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

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

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

Who? _____ What specialty? _____

5. Has the patient received a comprehensive evaluation including non-pharmacological therapies (behavioral, cognitive, family based)?

6. Does the patient have any preexisting medical conditions such as obesity or diabetes? _____

7. 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: _____

