

MOLINA HEALTHCARE Service Authorization (SA) Form ANTIPSYCHOTICS IN CHILDREN YOUNGER THAN 18 YEARS OLD

If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

Member's Last Name:	Member's First Name:	Member's First Name												
Last wante.	Weinber 3113t Name.													
MOLINA ID Number:	Date of Birth:	Date of Birth:												
Gender: Male Female	Weight in Kilograms:	Weight in Kilograms:												
PRESCRIBER INFORMATION														
Prescriber's Last Name:	Prescriber's First Name:													
NPI Number:		1 1												
Phone Number:	Fax Number:													
DRUG INFORMATION Drug Name/Form:		_												
Strength:														
Dosing Frequency:														
Length of Therapy:														
Quantity per Day:														
DIAGNOSIS AND MEDICAL INFORMATIO	l													
Antipsychotics in children younger than 18 following questions.	ears old—to receive approval for this drug, cor	mplete the												
Indicate the diagnoses being treated (include	e ALL ICD codes, if applicable):													

Member's Last Name: Member's First Name:																							
Doe	Does the member meet the following criteria?																						
1.	1. Is the prescribing provider a psychiatrist, neurologist, or developmental/behavioral pediatrician?																						
	Yes No																						
	If YES, document the specialty:																						
	If NO, has the provider consulted with a psychiatrist, neurologist, or developmental/behavioral pediatrician before prescribing the requested medication?																						
	Yes No																						
	If YES, date of consult:																						
2.	2. Has the member received a developmentally-appropriate, comprehensive psychiatric assessment with																						
	diagnoses, impairments, treatment target, and treatment plans clearly identified and documented?																						
		Yes		No	المان	2																	
	If NO, is one scheduled? Yes No																						
	If Y	ES, da	te psy	ychia	tric	asse	ssme	ent i	s sch	edul	ed:												
	If N	IO, che	eck al	l rea	sons	that	t app	oly:															
		Servi	ces n	ot av	ailak	ole ir	n are	a		Othe	er r	reasc	on: _										
3.	Is psy					-					-				-			II psy	chos	ocia	l trea	atme	nt
	with p	oarent	al inv		men	it co	ntin	ue to	or th	e dui	rati	ion c	ot me	edica	tion	ther	apy?						
_		Yes		No	_							_			_								
4.	Has in off-lal	itorme bel use		nsen	t for	this	me	dicat	tion	been	ok	otain	ed fr	om t	the p	aren	tor	guare	dian	for la	ibel a	and/	or
	_	Yes	·. 	No																			
5.	Is this	conti	nuati	on o	f the	rapy	/?																
		Yes (p						nt cli	nical	deta	ils	and	ratio	nale	for t	hera	ру)						
		No																					
6.	Is this	conti	nuati	on o	f the	rapy	/ be	ginni	ing ir	n-pat	ier	nt ho	spita	alizat	ion?								
		Yes (p	lease	pro	vide	date	es)] No														

Member's Last Name:												Member's First Name:												
List p	harma	ceuti	ical a	gent	s att	temp	oted	and	out	come	e:													
Preso	riber s	ignat	ture	(rea:	uirec	4)											- —	ate						
Prescriber signature (required) Prescriber signature, the physician confirms the above inform											ma	tion	ic ac	cura	to		5							

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.

Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **FAXED to 1-844-278-5731**, or you may call (800) 424-4518 (TTY 711)