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

Please use one form per member.

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

MCC ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

DIAGNOSIS AND MEDICAL INFORMATION

Antipsychotics in children younger than 18 years old—to receive approval for this drug, complete the following questions.

Indicate the diagnoses being treated (include ALL ICD codes, if applicable):

_____

_____

 Revision Date: 11/01/2020

Member's Last Name: **Member's First Name:**

Does the member meet the following criteria?

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. **Has the member received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target, and treatment plans clearly identified and documented?**
   ☐ Yes ☐ No
   If NO, is one scheduled?
   ☐ Yes ☐ No
   If YES, date psychiatric assessment is scheduled: _____
   If NO, check all reasons that apply:
   ☐ Services not available in area ☐ Other reason: _____

3. **Has informed consent for this medication been obtained from the parent or guardian for label and/or off-label use?**
   ☐ Yes ☐ No

4. **Has the member tried therapy and/or behavior modification techniques?**
   ☐ Yes ☐ No

5. **Have baseline weight and metabolic labs been obtained (blood glucose, and HgA1c, and cholesterol panel or LDL)?**
   ☐ Yes (please provide labs) ☐ No

6. **Is this continuation of therapy?**
   ☐ Yes (please provide pertinent clinical details and rationale for therapy)
   ☐ No

7. **Is this continuation of therapy beginning in-patient hospitalization?**
   ☐ Yes (please provide dates) ☐ No

Member's Last Name:

Member's First Name:

List pharmaceutical agents attempted and outcome:

_____

_____

_____

_____

_____

_____

_____ _____

Prescriber signature (required) **Date**

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 Complete Care.

The completed form may be **FAXED TO 1-800-922-3986** or mailed to:

Magellan Rx Management Prior Authorization Program
c/o Molina Complete Care
11013 West Broad Street
Glen Allen, VA 23060

Phone: 1-800-424-4524 (TTY 711)

