oklahoma complete health

Prior Authorization Request Form

Atypical Antipsychotics for Children under the age of 5

CoverMyMeds is the preferred way to submit this form. **https://www.covermymeds.com/main/prior-authorization-forms/**
OR FAX completed form to 1-844-235-5092
OR MAIL requests to: Centene Pharmacy Services Coverage Determinations| P.O. Box 31397 |Tampa, FL 33631-3397
OR CALL 1-833-331-1515 (SoonerSelect) or 1-833-655-0896 (SoonerSelect Children's Specialty Program)

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber name:	Member name:
Form Submitter name:	Member ID#
Provider NPI:	Group number (optional):
Fax:	Date of Birth:
Phone:	Relevant allergies (if any):

III. DRUG INFORMATION (One drug request per form)			
Drug name and strength:	Dosage form:	Dosage Interval (sig):	Qty per Day:

Diagnosis(es) relevant to this request: ☐ Autism Spectrum Disorder ☐ Disruptive Behavior Disorder
☐Other (specify):

Expected length of therapy:

Medication History for this Diagnosis

If this is a new request, please go to item D. If the member is currently treated on this medication, please go to item A.

A. How long has this member been treated on this medication?

B. Is this request for continuation of a previous approval? ☐ yes [go to item E] ☐ no / unknown [go to item C]

C. Has strength, dosage, or quantity required per day increased or decreased? ☐ yes [go to item E] ☐ no [go to item E]

D. ***Please check each box, go to item IV, and sign at the bottom.***

- ☐ **Member is diagnosed using current DSM criteria.**
- ☐ **Documentation is attached showing the following monitoring parameters set by the American Diabetes Association to ensure patient safety from known adverse effects:**
  1. Weight (BMI): **baseline**, four weeks, eight weeks, 12 weeks, then quarterly
  2. Waist circumference: **baseline**, then annually
  3. Blood pressure: **baseline**, 12 weeks, then annually
  4. Fasting plasma glucose or A1c: **baseline**, 12 weeks, then annually
  5. Fasting lipid profile: **baseline**, 12 weeks, and then every five years
  6. Prolactin level should be assessed if symptomatic.
  7. AIMS (Abnormal Involuntary Movement Scale): every six to 12 months.
- ☐ **The requested dose does NOT exceed the dosing guidelines below.**
  Risperidone: Starting dose is 0.125mg.
  Aripiprazole: Starting dose is 1mg/day.
- ☐ **Documentation (including office chart notes and lab results) of the below items is attached:**
  1. Chart documentation reporting a child psychiatry evaluation by a child psychiatrist **OR** chart documentation of a consultation with a child psychiatrist with a recommendation of an atypical antipsychotic trial.

a. Providers can register for the free, statewide Pediatric Mental Health Access Program, the Oklahoma Child and Adolescent Psychiatry and Mental Health Access Program for access to child psychiatry consultations 9-5AM, M-F. www.okcapmap.com.

2. Psychosocial issues and non-medical interventions being addressed by the clinical team.
3. Documentation of a comprehensive assessment including:
    a. An assessment of the full range of psychiatric symptoms and disorders, as well as impairment from these symptoms and disorders.
    b. A full developmental assessment.
    c. A full medical history, including a sleep history.
    d. A relevant medical work-up, physical examination and nutritional status evaluation.
    e. If relevant, an assessment of school functioning including academic, behavioral, and social aspects.
    f. An assessment of family psychiatric history, which includes past and current history of parental psychiatric illnesses, substance abuse and treatment history of parents, caregivers, siblings, and other relatives.
    g. An assessment of family structure and functioning, parent-child relationship, and interaction.
    h. An assessment of environmental risk factors and stressors including any history of abuse (physical, sexual) or neglect, traumatic life events, domestic violence, economic instability, etc.
4. Non-medication alternatives, evidence based psychotherapeutic interventions that have been attempted to address symptoms for 3-6 months before request for antipsychotic medications.
5. Information was given to the caregiver on risks, benefits, potential side effects, and alternatives.

E. ***Please check each box and sign at the bottom.***

☐ **Documentation (including office chart notes) of the below items is attached:**

1. Member has previously met initial approval criteria.
2. Psychosocial issues and non-medical interventions are being addressed by the clinical team.
3. Americana Diabetes Association monitoring
    a. Weight (BMI): baseline, four weeks, eight weeks, 12 weeks, then quarterly
    b. Waist circumference: baseline, then annually
    c. Blood pressure: baseline, 12 weeks, then annually
    d. Fasting plasma glucose or A1c: baseline, 12 weeks, then annually
    e. Fasting lipid profile: baseline, 12 weeks, and then every five years
    f. Prolactin level should be assessed if symptomatic.
    g. AIMS (Abnormal Involuntary Movement Scale): every six to 12 months.
4. Comprehensive follow up visits including:
    a. Assessment of symptoms with side effects noted.
    b. Response to therapy [labs, sign/symptom reduction, etc.]
5. If documentation shows that the member has been stable on the medication for a year or more, a discontinuation has been considered and if clinically indicated, attempted.
6. Patient was on the initial dose for a minimum of 4 weeks unless there is a contraindication (e.g. side effects).

☐ **The requested dose does <u>NOT</u> exceed the dosing guidelines below.**

Risperidone: Maximum dose is 3 mg/day.
Aripiprazole: Maximum dose is 7.5mg/day.

☐ **If the request is a change to an alternative atypical antipsychotic:**

a. A trial of aripiprazole or risperidone was tried.
b. A cross taper plan is documented.

IV. ADDITIONAL INFORMATION (OPTIONAL)

Appropriate clinical information to support the request based on medical necessity must be attached.	Provider Signature:	Date:

Pharmacy Services will respond via fax or phone within 24 hours of receipt. Requests for prior authorization (PA) must include member name and ID#, and drug name. **Incomplete forms will delay processing.** Please attach lab reports with requests when appropriate (e.g., fasting lipids, fasting glucose, etc.) For additional questions or to expedite this request, please call numbers listed above.