Antipsychotics for Children Prior Authorization Form

West Virginia Children's Health Insurance Program
Drug Prior Authorization Form
(website link; www.chip.wv.gov)

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Providers are required to complete Prior Authorization Drug form for Atypical Antipsychotic Drugs for Children and submit the documentation to the Rational Drug Therapy Program (RDTP) at (800) 847-3859 or fax form to (800) 531-7787.

Patient Name (Last) (First) (MI)		WV CHIP ID #	Date of Birth (MM/DD/YY)
Prescriber Name (Last) (First) (MI)			
Prescriber Address (Street) (City) (State) (ZIP)			
Prescriber 10-Digit NPI #	Phone # (111-222-3333)	Fax # (111-222-3333)	

Confidentiality Notice: This document contains confidential health information that is protected by law. This information is intended only for the use of the individual or entity names above. The intended recipient of this information should destroy the information after the purpose of its transmission has been accomplished or is responsible for protecting the information from any further disclosure. The intended recipient is prohibited from disclosing this information to any other party unless required to do so by law. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken en reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. Thank you.

Important Notes: Prior authorization for medical necessity does not guarantee payment. The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Check One: ☐ Age < 6 years ☐ Age 6 years to <18 years

Provider Type or Specialty:			
Medication Request: ☐ New ☐ Continuation	Patient: ☐ Male ☐ Female	Ht: Wt:	BMI:
Antipsychotic Medication/Strength:		Quantity:	
Directions:			

Target Symptoms: (Check all that apply)
☐ Severe Aggression ☐ Self-Injurious Behavior ☐ Extreme Impulsivity
☐ Extreme Irritability ☐ Psychotic Symptoms ☐ Other

DIAGNOSIS : ☐ ADHD ☐ Autism/PDD ☐ Schizophrenia ☐ ODD

☐Disruptive Behavior d/o ☐Bipolar Disorder ☐ Other: ICD Code:

Functional Impairment: ☐ 1 (Low) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (Severe)

Have metabolic monitoring labs* (fasting lipids and glucose) been performed within the last 6 months? ☐ Yes ☐ No

Are the lab values within normal range? ☐ Yes ☐ No

If the answer is no, have the labs been ordered? ☐ Yes ☐ No

Has an assessment for Tardive Dyskinesia been done in the last 6 months? AIMS: ☐ Yes ☐ No DISCUSS: ☐ Yes ☐ No

Next Appointment Date:

Current Therapy (Pharmacological and Non-Pharmacological):

If the drug being requested is a non-preferred drug on the WVCHIP Preferred Drug List, has the preferred drug(s) been attempted in the past? ☐ Yes ☐ No

Indicate clinical justification why a non-preferred drug is necessary over a preferred drug.

Attestation: Your signature certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

SIGNATURE – Prescriber Date Signed:

Required for Peer Review: Copies of medical records (diagnostic evaluation and recent chart notes), the original prescription and any related lab results. The provider must retain copies of all documentation for five years.

RDTP: ☐ Approval not Recommended ☐ Approval Recommended for _____months

Date: