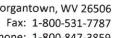
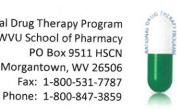
Antipsychotics for Children Prior Authorization Form



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 Morgantown, WV 26506





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 (La	(Last) (Firs			(MI)	(MI)			
Prescriber Address (Stro	eet) (Cit	у)	(State)	(ZIP)				
Prescriber 10-Digit NPI #	‡ Pho	ne # (111-222-	3333) Fa	Fax # (111-222-3333)				
Confidentiality Notice: information is intended information should dest responsible for protectin disclosing this information are hereby notified that documents is strictly protection and arrange for the return of the strictly protection.	only for the use of to roy the information on the information for to any other part any disclosure, copyohibited. If you have	he individual o after the purp rom any furthe y unless requir ring, distribution received this	r entity names above ose of its transmissic er disclosure. The in- red to do so by law. I on, or action taken en information in error,	e. The in has be tended of you are trelianced.	ntended rec een accomp recipient is pre not the ince ce on the co	ipient of this olished or is prohibited from tended recipient, you ntents of these		
Important Notes: Prior samples will not be cons that require prior author	idered when evalua	edical necessity ting the memb	y does not guarantee ers' medical condition	payme on or pri	ent. The use ior prescript	of pharmaceutical ion history for drugs		
Check One:	□ Age < 6 yea	rc	☐ Age 6 years to	-10 vo				
Provider Type or Special		13	La Age o years to	<10 yea	a12			
Medication Request:	l New □ Continua	cion Patient	: □ Male □ Female	Ht:	Wt:	BMI:		
Antipsychotic Medication/Strength:			Quantity:					
Directions:								
Target Symptoms: (Check all that apply)				Self-Injurious Behavior Extreme Impulsivity				
Target Symptoms: (Check all that apply)	☐ Severe Aggre	ssion 🗆	Self-Injurious Beh	avior	□ Extr	eme Impulsivity		

DIAGNOSIS: ADHD	☐ Autism/PDD ☐	3 Schizophre	enia	□ODD		
	□Disruptive Beha	avior d/o	□Bipola	r Disorder	□ Other:	ICD Code:
Functional Impairment:	□1(Low) □ 2	□ 3	□ 4	☐ 5 (Severe)		
Have metabolic monitoring	labs* (fasting lipids a	ind glucose)	been pe	rformed within	the last 6 month	s? 🗆 Yes 🗆 No
Are the lab values within no	ormal range?	☐ Yes	□No			
If the answer is no, have the	labs been ordered?	☐ Yes	□ No			
Has an assessment for Tardi	ve Dyskinesia been d	lone in the la	ast 6 moi	nths? AIMS:	□ Yes □ No	DISCUSS: ☐ Yes ☐ No
Next Appointment Date:						
Current Therapy (Pharmacol	ogical and Non-Phare	macological):			
If the drug being requested	d is a nan nucleus d	Liliana	140.461			
If the drug being requested attempted in the past?	□ Yes □ No	arug on th	ie WVCH	IP Preferred I	Orug List, has the	preferred drug(s) been
Indicate clinical justific	ation why a non-pro	eferred dru	ıg is nece	essary over a p	oreferred drug.	
Attestation: Vour signatur	ro cortifies that the	ahaya sassi		- di II		
Attestation: Your signature of the member, and is docurequest.	umented in your me	edical recor	ds. Me	edically neces	cy records must	xceed the medical needs be made available upon
SIGNATURE – Prescriber				Date	Signed:	
	1.1.2					
Required for Peer Review: prescription and any relate	Copies of medical idea and the p	records (dia rovider mu	agnostic Ist retain	evaluation an copies of all	d recent chart n documentation f	otes), the original for five years.
RDTP:	t Recommended		☐ Appr	oval Recomm	ended for	months
Data						
Date:						