

# UPMC HEALTH PLAN

## Antipsychotics – Children under 12 years of age

(Abilify, Clozapine, Zyprexa, Seroquel, Risperdal, Geodon, Invega, Fluphenazine, Haldol, Haloperidol, Loxapine, Moban, Navane, Orap, Perphenazine, Thiothixene, Trifluoperazine, Clorpromazine)

### Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-396-4139

FAX 412-454-7722

**PLEASE TYPE OR PRINT NEATLY**

*Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.*

<b>Office Contact:</b>		<b>Provider Specialty:</b>	
<b>Provider First Name:</b>		<b>Provider Last Name:</b>	
<b>Provider Phone:</b>		<b>Provider Fax:</b>	<b>Provider NPI #:</b>
<b>Patient Name:</b>		<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient DOB:</b>
			<b>Patient Age:</b>
<b>Drug Requested:</b>	<b>Strength:</b>	<b>Frequency:</b>	<b>Qty Dispensed:</b>
<input type="checkbox"/> Brand <input type="checkbox"/> Generic			
<i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i>			
<input type="checkbox"/> New Medication	<b>If Ongoing Provide Date Started:</b>	<b>If medication is ongoing, did the member show improvement while on therapy?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ongoing Medication			
<b>Diagnosis:</b>			<b>Date of diagnosis:</b>

### Medical History

Please include/attach chart documentation of relevant rating scale results and the complete DSM Multiaxial Diagnosis including the rule-out diagnoses.

Please include/attach chart documentation of prior behavioral health assessments/evaluations that support the need for treatment with an antipsychotic medication.

Please include/attach chart documentation of current behavioral difficulties including the frequency and severity and specify the presence of disruptive, aggressive or self-injurious behaviors.

Please include with chart documentation of other medication trials which have been implemented previously

Please include/attach chart documentation of non-pharmacologic behavioral therapies and members responses.

Please provide the following information:

Weight: _____	Date: _____	Height: _____	Date: _____
Lipid level: _____	Date: _____	BMI: _____	Date: _____
Glucose level: _____	Date: _____		

Is the member currently under the care of a child/adolescent psychiatrist, pediatric neurologist, or child development pediatrician?  Yes  No

If yes, provide physician's name: \_\_\_\_\_

**List any mental health hospitalization or residential treatment facility during the past 12 months:**

Facility Name	Date(s)	Duration