

UPMC HEALTH PLAN

Atypical Antipsychotics – Children under 12 years of age (Abilify, Clozapine, Zyprexa, Seroquel, Risperdal, Geodon, Invega)

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.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> New medication	<input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	
Diagnosis:		Date of diagnosis:	

Medical History

Is the member currently under the care of a child/adolescent psychiatrist, pediatric neurologist, or child development pediatrician?

Yes If yes, provide physician's name: _____ No

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

Facility Name	Date(s)	Duration

Please include relevant rating scale results. *Please attach additional information if necessary*

Please include documentation of prior behavioral health assessments that support the need for treatment with an antipsychotic medication. *Please attach additional information if necessary*

Please include documentation of behavioral treatments and members responses. *Please attach additional information if necessary*

Please provide the following information:

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

History of Formulary Medications Used to treat the above condition

(Specific Clinical Information is Essential to Determine Whether this Medication can be Approved)

Medication Trial/ Previous Therapy	Date of Therapy		Strength	Frequency	List Adverse Reactions/Side Effects/ Reason For Discontinuing
	Start Date	End Date			