Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

Reset Form | Print Form

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-888-865-6531 OR Mail request to: Pharmacy Services Prior Authorization Dept. 5 River Park Place East, Suite 210 | Fresno, CA 93720

Call 1-833-705-1351 to request a 72-hour supply of medication. Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, except during weekends and holidays. For immediate response on weekends and holidays,NurseWise will answer your call.

Antidepressant < 6 years

Note: Form must be completed in full.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number

Prescriber's Fax Number

PROVIDER TYPE OR SPECIALTY: _____ **CHILD UNDER STATE CARE/CUSTODY:** ☐ Yes ☐ No

PATIENT: ☐ Male ☐ Female **MEDICATION REQUEST:** ☐ New ☐ Continuation

HEIGHT: _____ ☐ in / ☐ cm **WEIGHT:** _____ ☐ lbs / ☐ kgs **BMI:** _____ ***BMI %:** _____

BMI Calculator: * https://www.cdc.gov/healthyweight/bmi/calculator.html

Medication:	Strength:	Quantity:	Directions (with titration or taper if indicated):

Target Symptoms (Check all that apply.):

- ☐ Depressive, Sad Mood or Anhedonia
- ☐ Irritability
- ☐ Somatic Complaints
- ☐ Appetite Disturbances
- ☐ Sleep Disturbances
- ☐ Anxiety
- ☐ Obsessions and/or Compulsions
- ☐ Aggression or self-injurious behavior
- ☐ Other: _____

Diagnosis:

- ☐ Major Depressive Disorder
- ☐ Disruptive Mood Dysregulation Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Generalized Anxiety Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Panic Disorder
- ☐ Other: _____

Severity of Target Symptoms: ☐ 1 Mild ☐ 2 Moderate ☐ 3 Marked ☐ 4 Severe ☐ 5 Extreme

Functional Impairment: ☐ 1 Mild ☐ 2 Moderate ☐ 3 Marked ☐ 4 Severe ☐ 5 Extreme

Previous Therapy (Pharmacological and Non-Pharmacological) including Effectiveness/Tolerability/Compliance:

Next Appointment date: _____

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Antidepressant < 6 years

Note: Form must be completed in full.

Review Criteria:

- The most current antidepressant prior authorization request form is required for review.
- All relevant sections of the antidepressant prior authorization form must be complete.
- The evaluation and progress notes must document target symptoms and behaviors.

Clinical Notes:

- Psychosocial treatments (e.g., dyadic therapy) must precede the use of psychotherapeutic medications and should continue if medications are prescribed.
- Risks and benefits should be carefully considered before prescribing an antidepressant.
- When discontinuing antidepressant medication prescribed for depression or anxiety, gradually taper down the dose to prevent discontinuation syndrome.

Calculation of BMI and BMI Percentile:

The Centers for Disease Control and Prevention (CDC) provides a ***BMI Calculator for Children and Teens*** that may be accessed at the following link: https://www.cdc.gov/healthyweight/bmi/calculator.html

Florida Medicaid Clinical Guidelines:

Access the following guidelines at http://floridabhcenter.org/index.html

- *Principles of Practice Regarding the Use of Psychotropic Medication in Children Under Age 6*
- *Florida Medicaid Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents*