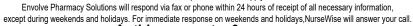
MEDICATION PRIOR AUTHORIZATION REQUEST FORM

FAX this completed form to 1-888-865-6531

OR Mail request to: Envolve Pharmacy Solutions Prior Authorization Dept.



Children's Medical Services
Health Plan
OPERATED BY SUNSHINE HEALTH





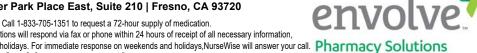
Antidepressant < 6 years
Note: Form must be completed in full.

Recipient's Medicaid ID# Date of Birth (MM/DD/YYYY)																		
Recipient's Full Name																		
Prescriber's Full Name												ı						
Prescriber's NPI																		
Prescriber's Phone Number	riber's Phone Number Prescriber's Fax Number																	
PROVIDER TYPE OR SPECIALTY:						CHILE	UNE	DER S	TATE	CAF	RE/CU	ISTO	DY:] Ye	S		No
PATIENT:	☐ Female		MEDICATION REQUEST: New										Continuation					
HEIGHT:																		
	Strength: Quantity: Directions (with titration or taper if indicated):										calcu	lator	r.html					
Medication:	Strength:	Quantity	/ :	Direct	ions (with til	ratio	n or	tape	r it in	idica	tea)						
Target Symptoms (Check all ti				Diagn														
□ Depressive, Sad Mood or Anhedonia□ Irritability□ Disruptive Mood Dysregulation Disorder																		
☐ Somatic Complaints		☐ Obsessive Compulsive Disorder																
☐ Appetite Disturbances						zed An												
☐ Sleep Disturbances ☐ Post-Traumatic Stress Disorder																		
Anxiety		☐ Panic Disorder ☐ Other:																
Obsessions and/or Compulsi				∐ Otl	ner:											_		
☐ Aggression or self-injurious b☐ Other:																		
Severity of Target Symptoms:	☐ 1 Mild			2 Mode	rate		3 Ma	rked			4 Se	evere	;		5 E	Extrer	ne	
Functional Impairment:	☐ 1 Mild			2 Mode	rate		3 Ma	rked			4 Se	evere)	[□ 5 E	Extrer	ne	
Previous Therapy (Pharmacol	ogical and Non-	Pharmac	ologi	cal) in	cludin	g Effec	ctive	ness	Tole	rabil	ity/C	omp	liand	e:				
Next Appointment date:																		
Prescriber's Signature:												Date	:					
REQUIRED FOR REVIEW: All copies of related labs. The pro										ent c	hart	note	es), a	nd t	he m	ost re	ecer	nt



MEDICATION PRIOR AUTHORIZATION REQUEST FORM FAX this completed form to 1-888-865-6531 OR Mail request to: Envolve Pharmacy Solutions Prior Authorization Dept.

5 River Park Place East, Suite 210 | Fresno, CA 93720



Envolve Pharmacy Solutions will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays. NurseWise will answer your call. Pharmacy Solutions 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

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.