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 Call 1-833-705-1351 to request a 72-hour supply of medication.



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



Antipsychotic (< 6 years of age) 180-day Maximum Approval Note: Form must be completed in full.

| Recipient's Medicaid ID# Date of Birth (MM/DD/YYYY) | | | | | | | | | | | | | | | | | | |
|---|-------------|---------------------|-------------------------|----------|--------|-----------|----------------|-------|----------------------|-------|-----------------|--------------|--------|--------|--------------|-------|--------|-------|
| | | | | <i>!</i> | | 1 | | | | | | | | | | | | |
| Recipient's Full Name | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| Prescriber's Full Name | | · | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| Prescriber's NPI | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| Prescriber's Phone Number | | | | | | | Pres | crib | er's | Fax I | Num | her | | | | | | |
| | | | | | | | | | |] _ | | | | _ | | | | |
| | | | | | | | | | | | | | | | | | | |
| PROVIDER TYPE OR SPECIALTY: | | | | | CI | HILD | UNDE | ER S | TATE | CAR | E/CU | STO | DY: | | Yes | | No |) |
| PATIENT: Male Female | | MEDICATION REQUEST: | | | | | | | ☐ New ☐ Continuation | | | | | | | | | |
| HEIGHT: in / _cm | WEIGHT | : | | ☐ Ib | os / [| ☐ kg | gs | | змі: | | | | *В | 3MI % | : _ | | | |
| | | | | ВМ | l Calc | ulato | r: * <u>ht</u> | tps:/ | /wwv | v.cdc | .gov | <u>/heal</u> | thyw | eight | <u>/bmi/</u> | calcu | lator | .html |
| Antipsychotic Medication/Strength: | Target | | ☐ Agg ☐ Self | | | havi | | Diagr | osis | : 🗆 🛭 | | | ectrur | m | | | | |
| | _ (check | all tha | t 🗌 Imp | ulsivity | us De | zi ia v i | Oi | | | |)isrup | otive | Beha | vior [| | | | |
| Quantity: | apply) - | | ☐ Irrita | - | | | | | | |)isrup)ther | | Mood | d Dys | regul | ation | Disor | rder |
| Directions: | | | | | | | _ | | | | | | | | | | | _ |
| | _ | | | | | | | | | | | | | | | | | _ |
| Severity of Target Symptoms 1 N | — Mild | | ☐ 2 Mc | nderate | د | <i>·</i> | 3 Mar | ·ked | | П | 4 Se | evere | | ſ | ⊐ 5 | Extre | me | |
| Functional Impairment: | | | ☐ 2 Moderate ☐ 3 Marked | | | | | | ☐ 4 Severe ☐ 5 Extr | | | | | | | | | |
| Previous Therapy (Pharmacological and No | | | | | | | | | Govern | | | | | | | | | |
| Frevious Therapy (Friainfacological and No | JII FIIAIII | iacoic | gicai). | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| Have metabolic monitoring labs* (fasting li | pids and | gluco | se) bee | n peri | forme | ed w | ithin | the I | ast 6 | 6 moi | nths | ? : | | | | Yes | | No |
| *Official lab results (most recent) must be attached. | For contin | uation | of therap | y, labs | are re | quire | d. D | ate:_ | | | | | | | | | | |
| Has an assessment for Tardive Dyskinesia | been do | ne in 1 | the last | 6 mor | nths? | Α | IMS: | | Yes | | No | | DISC | :SUS | | Yes | | No |
| *Official Form or notation (most recent) must be atta | ched. D | ate: | | | | | | | | | | | | | | | | |
| Monitoring Plan: RTC: | | _ | Labs: o | 7 | | ı | month | าร | | - | TD S | cree | n: q | | | mo | onths | ; |
| Next appointment date: | | _ | | | | | | | | | | | - | | | | | |
| Prescriber's Signature: | | | | | | | | | | D: | ate: | | | | | | | |
| REQUIRED FOR REVIEW: All copies of medical r | | | | | tions | and | recen | t cha | rt no | | - | | | | | es of | relate | ed |



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Antipsychotic (< 6 years of age)

180-day Maximum Approval Note: Form must be completed in full.

Review Criteria

- The most current antipsychotic prior authorization request form is required for review.
- All relevant sections of the antipsychotic prior authorization form must be complete.
- To calculate the 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
- The evaluation and progress notes must document target symptoms and behaviors.
- Continuation requests require documentation to demonstrate monitoring for movement disorders. Find screening tools (AIMS, DISCUS) at: http://floridabhcenter.org/assessment-scales.html
- Continuation requests require the attachment of the most recent metabolic monitoring labs to include
 - Fasting glucose and fasting lipids.

Clinical Notes

- Psychosocial treatments should precede the use of psychotherapeutic medications and should continue if medications are prescribed.
- Risks and benefits should be carefully considered before prescribing an antipsychotic.
- Prior to starting an antipsychotic medication, baseline measures should be obtained for weight, height, BMI, blood pressure, fasting glucose and fasting lipids.
- Assessments obtained at baseline should be repeated at three months and at least annually to assure safety and efficacy with the use of antipsychotic treatment.
- Fasting glucose and lipids may need to be assessed every six months to provide optimal monitoring in young children.
- Assessment for movement disorders should be performed during the initial titration, at three months and annually.

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

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