COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

ANTIPSYCHOTICS IN CHILDREN YOUNGER THAN 18 YEARS OLD

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

PATIENT INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

 Revision Date: 10/28/2022

Patient's Last Name:

Patient's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

Antipsychotics in Children Younger than 18 Years Old – to receive an approval for this drug, complete the following questions.

Indicate the Diagnoses Being Treated (Include ALL ICD Codes if Applicable):

_____

Does the patient meet the following criteria?

1. **Is the prescribing provider a Psychiatrist, Neurologist, or a Developmental/Behavioral Pediatrician?**

   ☐ Yes ☐ No

   If yes, document the specialty: _____

   If no, has the provider consulted with a Psychiatrist, Neurologist, or a Developmental/Behavioral Pediatrician before prescribing the requested medication?

   ☐ Yes ☐ No

   If yes, date of consult: _____

2. **Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented?**

   ☐ Yes ☐ No

   If no, is one scheduled?

   ☐ Yes ☐ No

   If yes, date psychiatric assessment is scheduled: _____

   If no, check all reasons that apply:

   ☐ Services not available in area ☐ List Other reason: _____

3. **Psychosocial treatment is in place without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy?**

   ☐ Yes ☐ No

4. **Has informed consent for this medication been obtained from the parent or guardian?**

   ☐ Yes ☐ No

5. **Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated?**

   ☐ Yes ☐ No

(Form continued on next page.)

Patient's Last Name:

Patient's First Name:

PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

Name of Program: _____

Enrolled in Program on: _____

List pharmaceutical agents attempted and outcome:

_____

_____

If this request is denied or if more information is required, please list a phone number where you can be reached for a peer-to-peer consultation with the program's Board Certified Pediatric Psychiatrist.

Phone Number:

– –

Last Name:

First Name:

_____ _____

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by patient records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060