NC Medicaid and NC Health Choice Pharmacy Prior Approval Request for

A+KIDS: Antipsychotics-Keeping it Documented for Safety

Beneficiaries 17 Years of Age and Younger

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (In days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days
12. Dose Instructions: _____

Clinical Information

For Non-preferred Medications:

1. ☐ Failed 1 preferred drug? ☐ **Yes** ☐ **No**
   List preferred drugs failed:_____
   1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
   _____
3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
4. ☐ Age specific indications. Please give patient age and explain:_____
5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:
   _____
6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____
   _____

Criteria for All medications:

7. What is the beneficiary's Primary Psychiatric diagnosis? ☐ Attention Deficit-Hyperactivity Disorder ☐ Bipolar Disorder
   ☐ Disruptive Behavior Disorder ☐ Mood Disorder-NOS ☐ Any Pervasive Development Disorder
   ☐ PTSD ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Tourette's Syndrome ☐ Other: _____
8. What is the beneficiary's target symptom? ☐ Aggression ☐ Impulsivity ☐ Inattentiveness ☐ Irritability ☐ Mania
   ☐ Oppositional ☐ Psychosis ☐ Other: _____
9. Measurements: Obtained baseline BMI ☐ **Yes** ☐ **No** BMI measured at regular intervals ☐ **Yes** ☐ **No** 10. Labs: Obtained at baseline and monitored at regular intervals: Lipid Profile ☐ **Yes** ☐ **No** Glucose Level ☐ **Yes** ☐ **No** Fasting Glucose Monitored ☐ **Yes** ☐ **No**

If labs were not completed select one of the following reasons: ☐ Pending ☐ Not clinically indicated ☐ Unable to obtain

11. Has the beneficiary had clinical improvement since starting the Drug Treatment? Please select most appropriate:
    ☐ Modestly improved ☐ Much improved ☐ Very much improved ☐ No change ☐ Not accessed/Not applicable
    ☐ Modestly worse ☐ Much worse ☐ Very much worse
12. Adverse effects over the past week:

Daytime Sedation:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Significant restlessness:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Stiffness/Dystonia/Tremor:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Other Dyskinesia:	☐ Mild	☐ Moderate	☐ Severe	☐ None

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSRA at (855) 710-1969 Pharmacy PA Call Center: (866) 246-8505