

## Psychotropic Agents for Children and Adolescents

**Submit request to:** Fax: 855-455-3303

**Purpose:** For a prescribing physician to request prior authorization for a psychotropic agent for a recipient under age 18. For the purpose of this form, psychotropic agents are: antianxiety agents, anticonvulsants, antidepressants, antipsychotics, lithium preparations and sedatives. **Request only one drug per form.**

**Questions:** If you have questions, call the Clinical Pharmacy Services Call Center for Nevada Medicaid at 855-455-3311

<b>DATE OF REQUEST:</b>		
<b>RECIPIENT INFORMATION</b>		
Last Name, First Name, Middle Initial:		Date of Birth:
Recipient ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
<b>PRESCRIBING PROVIDER INFORMATION</b>		
Name:		NPI:
Phone:		Fax (required):
Person to contact regarding this request:		
<b>DIAGNOSIS AND REQUESTED DRUG</b>		
Applicable ICD-9 code and diagnosis <b>or</b> symptom/side effect <b>(REQUIRED)</b> :		
Drug Name:	Strength:	<input type="checkbox"/> Generic substitution not permitted
Dosage:	Duration:	
<input type="checkbox"/> The requested drug is an anticonvulsant being used to treat a seizure disorder. Coverage criteria below do not apply to this agent. <i>(Check box if applicable.)</i>		
<b>COVERAGE CRITERIA</b>		
<p>For <u>all</u> requests (excluding anticonvulsants used to treat a seizure disorder), the following two conditions must be met. <i>Check the applicable boxes to indicate each item as true for the recipient:</i></p> <p><input type="checkbox"/> Each prescribed drug must independently treat a specific diagnosis or symptom/side effect <b>and</b>;</p> <p><input type="checkbox"/> The recipient must have a comprehensive treatment plan that addresses education, behavioral management, home environment and psychotherapy.</p> <p><b>Multi-Agent Criteria</b> (not applicable if recipient is using single-agent therapy for one diagnosis):</p> <p>Recipients age 0-17 who are using multi-agents for one diagnosis must meet conditions 1 and 2 above <b>and</b> at least 1 condition below. <i>Check the applicable boxes to indicate each item as true for the recipient:</i></p> <p><input type="checkbox"/> Recipient failed single-agent treatment in one therapeutic class requiring a switch to a new agent in this class.</p> <p><input type="checkbox"/> Recipient failed single-agent treatment in one therapeutic class requiring two agents in this class.</p> <p><input type="checkbox"/> Recipient currently receives two or more psychotropic agents. An additional psychotropic agent is needed to treat a new diagnosis or a unique symptom/side effect.</p> <p><b>Stabilization Criteria:</b></p> <p><i>Check the applicable boxes to indicate each item as true for the recipient:</i></p> <p><input type="checkbox"/> The recipient is stabilized on the requested medication.</p> <p><input type="checkbox"/> The recipient is seen by the prescribing physician on a monthly or more frequent basis.</p> <p><input type="checkbox"/> The recipient is seen by the prescribing physician every three months or more frequently.</p> <p><b>Other Clinical Information</b> <i>(if applicable):</i></p> <p><input type="checkbox"/> The non-preferred drug is being requested for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication that is unique to the requested drug (document diagnosis above).</p> <p><input type="checkbox"/> The recipient was recently discharged from a mental health facility on the requested medication. Date: _____.</p>		
<b>PROVIDER CERTIFICATION – Prescriber's signature and date required.</b>		
<b>I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.</b>		
<b>Prescriber's Signature:</b> _____		<b>Date:</b> _____

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*