Prior Authorization Request
Hewlett Packard Enterprise – OptumRx

# 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

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| **DATE OF REQUEST:** | | |
| **RECIPIENT INFORMATION** | | |
| Last Name, First Name, Middle Initial: | | Date of Birth: |
| Recipient ID: | Gender: ☐ Male ☐ Female | Phone: |
| **PRESCRIBING PROVIDER INFORMATION** | | |
| Name: | NPI: | |
| Phone: | Fax (required): | |
| Person to contact regarding this request: | | |
| **DIAGNOSIS AND REQUESTED DRUG** | | |
| Applicable ICD-9 code and diagnosis **or** symptom/side effect **(REQUIRED)**: | | |
| Drug Name: | Strength: | ☐ Generic substitution not permitted |
| Dosage: | Duration: | |

☐ The requested drug is an anticonvulsant being used to treat a seizure disorder. Coverage criteria below do not apply to this agent. *(Check box if applicable.)*

## COVERAGE CRITERIA

For all requests (excluding anticonvulsants used to treat a seizure disorder), the following two conditions must be met.
*Check the applicable boxes to indicate each item as true for the recipient:*

☐ Each prescribed drug must independently treat a specific diagnosis or symptom/side effect **and;**
☐ The recipient must have a comprehensive treatment plan that addresses education, behavioral management, home environment and psychotherapy.

**Multi-Agent Criteria** (not applicable if recipient is using single-agent therapy for one diagnosis)**:**
Recipients age 0-17 who are using multi-agents for one diagnosis must meet conditions 1 and 2 above **and** at least 1 condition below. *Check the applicable boxes to indicate each item as true for the recipient:*

☐ Recipient failed single-agent treatment in one therapeutic class requiring a switch to a new agent in this class.
☐ Recipient failed single-agent treatment in one therapeutic class requiring two agents in this class.
☐ 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.

**Stabilization Criteria:**
*Check the applicable boxes to indicate each item as true for the recipient:*

☐ The recipient is stabilized on the requested medication.
☐ The recipient is seen by the prescribing physician on a monthly or more frequent basis.
☐ The recipient is seen by the prescribing physician every three months or more frequently.

**Other Clinical Information** *(if applicable)***:**

☐ 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).
☐ The recipient was recently discharged from a mental health facility on the requested medication. Date: _____.

## PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

**I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.**
**Prescriber's Signature:** _____ **Date:** _____