Prior Authorization Request
HP Enterprise Services – Catamaran

Psychotropic Agents for Children and Adolescents

Submit completed request to: Fax: 855-455-3303. Incomplete forms will be returned.
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. ☐ **Letter of Medical Necessity included (For ages 0-5 only).***
Questions: If you have questions, call the Clinical Pharmacy Services Call Center for Nevada Medicaid at 855-455-3311.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last Name, First Name, Middle Initial:		Date of Birth:
Recipient ID:	Gender: Male Female	Phone:

PRESCRIBING PROVIDER INFORMATION (Required)	
Last Name, First name, Title:	NPI:
Phone:	Fax:
Person to contact regarding this request:	Prescriber Specialty:

DIAGNOSIS (Required)

Specific treatment diagnosis and diagnosis code:_____
List any other pertinent diagnoses:_____
☐ **The requested drug is an anticonvulsant used to treat a seizure disorder.** ***(Check if applicable)***
Per Nevada Medicaid Services Manual (MSM) Chapter 1200, Appendix A.1.N.2g: Treatment for seizure disorders with the following diagnoses beginning with 345 (Epilepsy), beginning with 780.3 (Convulsions) and 779.0 (Convulsions in Newborn) will be approved. These diagnoses written on the prescription and on the claim will bypass the prior authorization requirement in the pharmacy POS or the prior authorization requirement will be overridden for anticonvulsant medications when the prescriber has a provider specialty code of 126, neurology or 135, pediatric neurology, in the POS system.

TARGET SYMPTOM/SIDE EFFECT (Required)

Select one of the primary target symptoms:
☐ Psychosis ☐ Mania ☐ Irritability ☐ Aggression ☐ Impulsivity ☐ Inattentiveness ☐ Oppositional
☐ Other_____
And/or Select one of the primary target side effects:
☐ Sedation ☐ Restlessness ☐ Stiffness/Dystonia/Tremor ☐ Other Dyskinesia ☐ Other_____

Requested Drug (Required)		
Drug Name:	Strength:	☐ Generic substitution not permitted
Dosing Instructions:	Length of Therapy:	

List All Current Psychotropic Agents (Required) Document agent and diagnosis/indication
(antianxiety agents, anticonvulsants, antidepressants, antipsychotics, lithium preparations and sedatives)

COVERAGE CRITERIA (Required) ***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 **and;**
☐ The recipient is in initial treatment or is **unstable** on the medication therapy, and documentation is available to support a monthly or more frequent visit with the prescribing practitioner **or;**
☐ The recipient is **stable** in their medication therapy and documentation is available to support visits with the treating physician at least every three months.

Multi-Agent Criteria (To be considered for multiple drug therapy for one diagnosis, treatment of unique symptoms, or treatment of medication side effects must be documented.) ***Check the applicable boxes to indicate each item as true for the recipient:***
☐ Recipient failed single-agent treatment in one therapeutic class requiring two agents in the same class.
Failed single agent drug name, strength and dosage:_____
☐ An additional psychotropic agent is needed to treat a unique symptom/side effect. (*Symptom/Side effect must be indicated under "Target Symptom/Side Effect" above*.)

COVERAGE CRITERIA for non-preferred agents (Required if applicable)

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

☐ The recipient has allergy(ies) to **ALL** preferred medications (document each agent and allergy below).
☐ The recipient has a contraindication(s) to **ALL** preferred medications (document each agent and contraindication below).
☐ The recipient has a drug-to-drug interaction(s) with **ALL** preferred medications (document each agent and interaction below).
☐ The recipient has had therapeutic failure with at least two preferred psychotropics **or,** if the request is for an antipsychotic, the recipient has had therapeutic failure with at least one preferred antipsychotic (document the agents and reasons below).
☐ The requested agent is being used for an indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA-approved indication. Cite peer-reviewed data source:_____

_____

Document each agent from the above section or any other agents previously tried and failed:

Drug Name:	**Reason:**	**Date(s) of Trial:**

Other Clinical Information (Required if applicable) ***Check the boxes to indicate each item as true for the recipient***

☐ The drug being requested is for off label use due to treatment of a unique indication, symptom, side effect, or outside of the FDA approved age range, and the treatment is supported by peer-reviewed literature **(please include a citation of the literature). ***A letter of medical necessity is also required if medication is being prescribed for a child 0-5 years of age.
☐ 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:** _____

Providers are bound by both federal and state statutes and regulations, DHCFP policy and the DHCFP provider agreement to cooperate and provide any and all documentation (e.g., medical records, charts, billing information and any other documentation) requested by the DHCFP or other state and/or federal officials or their authorized agents for the purpose of determining the validity of claims and the reasonableness and necessity of all services billed to and paid by the DHCFP.

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.