AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Antipsychotic Medication in Children (0-17 years of Age)

Drug Name:	Dosage Form/Strength:	Quantity:
Administration Schedule:	Total Daily Dose:	❑ New Therapy **OR** ❑ Continuation Therapy

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- Will the member be discontinuing a previously prescribed antipsychotic medication if approved for requested medication?

  ❑ Yes OR ❑ No

- If yes, please list the medication that will be discontinued and the medication that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

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Prescriber Information

Is the prescriber a Psychiatrist, Neurologist or a Developmental/Behavioral Pediatrician?

Indicate Specialty: _____ ❑ Yes **OR** ❑ No

If No, has the prescriber consulted with a Psychiatrist, Neurologist, or Developmental/Behavioral Pediatrician prior to prescribing the requested medication? ❑ Yes **OR** ❑ No

If Yes, Name: _____ Specialty: _____

Date of Consult: _____

Diagnosis and Symptoms

ICD Diagnosis Code(s):	Diagnosis Code Description(s):

Target Symptoms: (check all that apply) ❑ Severe Aggression ❑ Extreme Irritability
❑ Extreme Impulsivity ❑ Self-Injurious Behavior ❑ Psychotic Symptoms
❑ Other: _____

Medical/Clinical Information

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

❑ Yes **OR** ❑ No

If No, is one scheduled? ❑ Yes **OR** ❑ No

If Yes, date psychiatric assessment is scheduled: _____

If No, check all reasons that apply: ❑ Services not available in area ❑ List Other reason

_____

Psychosocial treatment is in place without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy? ❑ Yes **OR** ❑ No

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PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

Name of program: _____

Enrolled in program on: _____

If assistance is needed locating a provider, please contact AvMed Health Plans Member Services Department.

Has informed consent for this medication been obtained from parent or guardian? ❑ Yes **OR** ❑ No

Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated? ❑ Yes **OR** ❑ No

Current/Past Therapy

Current Therapy: (pharmacological and non-pharmacological)

_____

_____

Previous Therapy: (Include Outcomes, pharmacological and non-pharmacological)

_____

_____

_____

If the drug requested is: Caplyta®, Fanapt®, lurasidone (Latuda®), paliperidone (Invega®), Rexulti®, Saphris®, or Vraylar®, the following criteria must be met:

❑ Patient has tried and failed at least **30 days** of therapy with **two (2)** of the following:

❑ risperidone	❑ quetiapine/XR	❑ aripiprazole
❑ ziprasidone	❑ olanzapine	

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** 11/27/2016
REVISED/UPDATED/REFORMATTED: ~~12/9/2016; 1/20/2017; 1/27/2017; 8/9/2017; 9/29/2017; 5/30/2018; 8/8/2018; 9/28/2018; 1/7/2019; 5/10/2019; 12/7/2020; 10/26/2023; 7/1/2024;~~ **10/8/2025**