KAISER PERMANENTE®

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Antipsychotic Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Antipsychotic Agents.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the provider a Psychiatrist, Neurologist, or Developmental/Behavioral Pediatrician or has the provider consulted with one of these specialists prior to prescribing the requested agent? □ No □ Yes

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:
□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

Diagnosis: _____

6-Clinical Criteria

1. Is the patient ≤ 17 years old?
   □ No □ Yes If, No, Prior Authorization is not required
2. Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented?
   □ No □ Yes
   If no, is one scheduled?
   □ No □ Yes If Yes, date psychiatric assessment is scheduled:_____
   If no, check all reasons that apply:
   □ Services not available in area
   □ Other Reasons_____
2. Psychosocial treatment is in place without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy?
   □ No □ Yes
3. Has informed consent for this medication been obtained from the parent or guardian?
   □ No □ Yes
4. Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated?
   □ No □ Yes

_____

PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

Name of Program:_____
Enrolled in Program on:_____
List pharmaceutical agents attempted and outcome:_____

7 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____
_____
_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**