PRIOR AUTHORIZATION REQUEST FORM

Virginia Premier Antipsychotic AL/NF

Phone: 800-727-7536 Fax back to: 833-770-7569

Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ Expedited/Urgent

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Is request for initial or continuing therapy?

☐ Initial ☐ Continuing

Q2. For continuing therapy, please specify start date (MM/YY). (If the request is for continuing therapy and the requested medication was approved by a previous Health Plan, please submit documentation of the previous approval to be considered)

Q3. Is member less than 18 years of age?

☐ Yes ☐ No

Q4. Please indicate the patient's diagnosis below:

☐ Autistic disorder - irritability
☐ Autistic disorder - psychomotor agitation
☐ Bipolar I disorder
☐ Gilles de la Tourette's syndrome
☐ Hyperactive behavior
☐ Psychotic disorder
☐ Schizophrenia
☐ Severe problematic behavior
☐ Other

Q5. If the patient’s diagnosis is OTHER, please specify below. IF THE REQUEST IS FOR OFF-LABEL USE you must provide a unique peer-reviewed journal article to support the request.

Q6. Is the medication being prescribed by a psychiatrist, neurologist, or Developmental/Behavioral Pediatrician?

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Patient Name:	**Prescriber Name:**

☐ Psychiatrist
☐ Neurologist
☐ Developmental/Behavioral Pediatrician
☐ None of the above

Q7. If no, prescriber must submit with the request proof of a psychiatric consultation. Is this submitted with the request?

☐ Yes ☐ No

Q8. Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target, and treatment plans clearly identified and documented?

☐ Yes ☐ No ☐ Unknown

Q9. Has psychosocial treatment been in place without adequate response and psychosocial treatment with parental/guardian involvement will continue for the duration of medication therapy?

☐ Yes ☐ No ☐ Unknown

Q10. Please provide a list of pharmaceutical agents attempted and outcome:

Q11. Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated?

☐ Yes ☐ No

Q12. Virginia Premier does not recognize the use of drug samples to meet clinical criteria requirements for prior drug use for drugs covered under the pharmacy benefit or drugs administered in the physician office or other outpatient setting. A physician's statement that samples have been used cannot be used as documentation of prior drug use. Do you attest that you have read and understand this statement and are not indicating sample usage as continuing therapy?

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Prescriber Signature

Date