OFFICE OF THE GOVERNOR | MISSISSIPPI DIVISION OF MEDICAID

PRIOR AUTHORIZATION CRITERIA

Multiple Antipsychotics for Patients Less Than Age 18 Years (Typical and Atypical Antipsychotics, Preferred and Non-Preferred Medications)

MISSISSIPPI DIVISION OF MEDICAID

Beneficiary ID#: _____ **Beneficiary Full Name:** _____

Gender: ☐ Male ☐ Female **Age**:_____

Beneficiary under State Care/Custody: ☐ Yes ☐ No ☐ Unknown

Medication Request: ☐New ☐Continuation *(Authorization is for 12 months)*

Diagnosis: *(check all that apply)*

☐ ADHD ☐ Disruptive Behavior Disorder ☐ Schizoaffective Disorder ☐ Autism Spectrum

☐ Disruptive Mood Dysregulation Disorder ☐ Schizophrenia ☐ Bipolar Disorder ☐ Tourette's

Other: _____

Height: _____ in. ***OR*** _____cm. **Weight:** _____ lb. ***OR*** _____kg. **BMI**: ____

Target Symptoms: (check all that apply) ☐ Aggression ☐Impulsivity ☐Irritability

Mood Instability: ☐ Depressed ☐Manic ☐ Psychosis ☐ Self-Injurious Behavior ☐ Other: _____

Overall Target Symptoms Severity: ☐1-Mild ☐ 2-Moderate ☐ 3-Severe

Functional Impairment: ☐1-Mild ☐ 2-Moderate ☐ 3-Severe

List All Current Medications:_____

_____

Antipsychotic Requested	Strength	Directions	Quantity

☐ Yes ☐ No ☐ NA If prescribing more than one (1) antipsychotic, is the plan to cross taper, with antipsychotic dual/monotherapy resumed within the next ninety (90) days? (if applicable)

IF YES: Which of the medication(s) listed above will be discontinued?_____

_____

IF NO: What is the rationale for continuing treatment with two (2) or more antipsychotics? _____

_____

☐Yes ☐ No Beneficiary has chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies, such as, but not limited to, evidence based behavioral, cognitive, and family based therapies.

☐ Yes ☐ No Beneficiary is currently receiving non-pharmacologic/psychosocial services.

☐ Yes ☐ No For a beneficiary not currently receiving non-pharmacologic/psychosocial services, a referral has been made and an appointment is pending. If there is no pending appointment, provide explanation below:

_____

_____

Has an assessment for Extrapyramidal Symptoms, including Tardive Dyskinesia (TD) been done in the last 26 weeks (6 months)? **AIMS**: ☐Yes ☐No ***OR*** **DISCUS**: ☐Yes ☐No **AIMS/DISCUS Forms**

☐ Yes ☐ No Medical record documentation of metabolic monitoring: weight or BMI, blood pressure, fasting glucose, and a fasting lipid panel within the last 12 months.

Next appointment date: _____

I certify that the benefits of antipsychotic treatment outweigh the risks of treatment.

Prescriber's Signature: _____ **Specialty:** _____