

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: _____

Is the diagnosis for the agent requested a FDA approved indication? Yes No If no, please sign the below waiver.

Waiver (if applicable): I am aware that this drug is not FDA approved or has limitations for use due to:

the beneficiary's age medical condition and/or diagnosis

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 Extrapyrimal 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: _____