Magellan COMPLETE CARE

MAGELLAN COMPLETE CARE OF VIRGINIA – CCC PLUS

Service Authorization (SA) Form

ANTIPSYCHOTICS IN CHILDREN YOUNGER THAN 18 YEARS OLD

If the following information is not complete, correct, or legible, the PA process can be delayed.
Please use one form per member.

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

MCC VA ID Number:

Date of Birth: – –

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: ______________________________

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

NPI Number:

Phone Number: – –

Fax Number: – –

DRUG INFORMATION

Drug Name/Form: ______________________________

Strength: ______________________________

Dosing Frequency: ______________________________

Length of Therapy: ______________________________

Quantity per Day: ______________________________

(Form continued on next page.)

© 2018, Magellan Health, Inc. All Rights Reserved.

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

DIAGNOSIS AND MEDICAL INFORMATION

Antipsychotics in Children Younger than 18 Years Old – to receive approval for this drug, complete the following questions.

Indicate the diagnoses being treated (include ALL ICD codes, if applicable):

____

____

Does the member meet the following criteria?

1. **Is the prescribing provider a psychiatrist, neurologist, or developmental/behavioral pediatrician?**

   ☐ Yes ☐ No

   If YES, document the specialty: ____

   If NO, has the provider consulted with a psychiatrist, neurologist, or developmental/behavioral pediatrician before prescribing the requested medication?

   ☐ Yes ☐ No

   If YES, date of consult: ____

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

   ☐ Yes ☐ No

   If NO, is one scheduled?

   ☐ Yes ☐ No

   If YES, date psychiatric assessment is scheduled: ______________________________

   If NO, check all reasons that apply:

   ☐ Services not available in area ☐ Other reason: ______________________________

3. **Psychosocial treatment is in place without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy?**

   ☐ Yes ☐ No

4. **Has informed consent for this medication been obtained from the parent or guardian?**

   ☐ Yes ☐ No

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

   ☐ Yes ☐ No

(Form continued on next page.)

© 2018, Magellan Health, Inc. All Rights Reserved.

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

List pharmaceutical agents attempted and outcome:

____

____

____

____

____

____

____

____

____ ______________________

Prescriber Signature (Required) **Date**

By signature, the Physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process. Submission of documentation does NOT guarantee coverage by Magellan Complete Care of Virginia.

The completed form may be **FAXED TO 1-800-922-3986** or mailed to:

Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
11013 West Broad Street
Glen Allen, VA 23060

Phone: 1-800-424-4524 (TTY 711)

© 2018, Magellan Health, Inc. All Rights Reserved.