

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:

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Member's First Name:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MCC VA ID Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date of Birth:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Gender: Male Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Prescriber's Last Name:

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Prescriber's First Name:

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NPI Number:

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Phone Number:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Fax Number:

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DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

Member's Last Name:

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Member's First Name:

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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.)

Member's Last Name:

Member's First Name:

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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 – Medallion 4.0.

The completed form may be **FAXED TO 1-800-424-7581** or mailed to:

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

Phone: 1-800-424-4518 (TTY 711)