**AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM**

**ANTIPSYCHOTICS IN CHILDREN YOUNGER THAN 18 YEARS OLD**

**Fax back to: 1-855-799-2553**

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

## PATIENT INFORMATION

**Last Name:** **First Name:**

**Medicaid ID Number:** **Date of Birth:** – –

**Gender:** ☐ **Male** ☐ **Female** **Weight in Kilograms**: ____________________________

## PRESCRIBER INFORMATION

**Last Name:** **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.)*

**Patient's Last Name:** | | | | | | | | | | | |

**Patient's First Name:** | | | | | | | | | | | |

## DIAGNOSIS AND MEDICAL INFORMATION

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

**Indicate the Diagnoses Being Treated (Include ALL ICD Codes if Applicable):**

______________________________________________________________________________

**Does the patient meet the following criteria?**

1. **Is the prescribing provider a Psychiatrist, Neurologist, or a Developmental/Behavioral Pediatrician?**
   ☐ Yes ☐ No
   If yes, document the specialty: ______________________________
   If no, has the provider consulted with a Psychiatrist, Neurologist, or a Developmental/Behavioral Pediatrician before prescribing the requested medication?
   ☐ Yes ☐ No
   If yes, date of consult: ______________________________
2. **Has the patient 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 ☐ List 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.)*

**Patient's Last Name:** | | | | | | | | | | | | |

**Patient's First Name:** | | | | | | | | | | | | |

## PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

**Name of Program**: ______________________________

**Enrolled in Program on**: ______________________________

**List pharmaceutical agents attempted and outcome**:

______________________________

______________________________

**If this request is denied or if more information is required, please list a phone number where you can be reached for a peer-to-peer consultation with the program's Board Certified Pediatric Psychiatrist.**

**Phone Number:**

☐☐☐ – ☐☐☐ – ☐☐☐☐

______________________________ ______________

**Prescriber Signature (Required)** **Date**

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

**Please include ALL requested information; Incomplete forms will delay the PA process.**

Submission of documentation does NOT guarantee coverage.