Anthem. HealthKeepers Plus
Offered by HealthKeepers, Inc.

Prior Authorization Form

Antipsychotics in Children Younger than 18 Years Old

Please note, this communication applies to Anthem HealthKeepers Plus Medicaid products offered by HealthKeepers, Inc. If the following information is not complete, correct, or legible, the PA process can be delayed.

Use one form per Anthem HealthKeepers Plus member please.

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 AND MEDICAL INFORMATION

DRUG NAME: **DOSAGE FORM:** **STRENGTH:**

ADMINISTRATION SCHEDULE OR DOSING FREQUENCY: **QUANTITY REQUESTED:** **TOTAL DAILY DOSE:**

INDICATE THE DIAGNOSES BEING TREATED (INCLUDE ALL ICD CODES IF APPLICABLE):

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:

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:

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

Has informed consent for this medication been obtained from the parent or guardian? ☐ Yes ☐ No

Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated? ☐ Yes ☐ No

PATIENT'S CURRENT BEHAVIOR HEALTH PROGRAM INFORMATION

NAME OF PROGRAM: **ENROLLED IN PROGRAM ON:**

List pharmaceutical agents attempted and outcome:

1.

2.

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: – –

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LAST NAME:

FIRST NAME:

Prescriber Signature (Required)

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

Date

PLEASE INCLUDE ALL REQUESTED INFORMATION
INCOMPLETE FORMS WILL DELAY THE PRIOR AUTHORIZATION PROCESS

Requests for prior authorization (PA) must include patient name, Medicaid ID#, drug name, and appropriate clinical information to support the request on the basis of medical necessity. Please include all requested information; incomplete forms will delay the PA process.

The completed form may be **FAXED TO 844-512-7020 for Retail Pharmacy or 844-512-7022 for Medical Injectables.**

If you have any questions about this communication, call Anthem HealthKeepers Plus Provider Services at **800-901-0020.**

PRIOR AUTHORIZATION CRITERIA IS SUBJECT TO CHANGE

https://providers.anthem.com/va

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