DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00556 (01/2016)

STATE OF WISCONSIN
Wis. Admin. Code § DHS 107.10(2)

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR ANTIPSYCHOTIC DRUGS FOR CHILDREN 7 YEARS OF AGE AND YOUNGER

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 7 Years of Age and Younger Completion Instructions, F-00556A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Antipsychotic Drugs for Children 7 Years of Age and Younger form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number	3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name	5. Drug Strength
6. National Drug Code (NDC)	7. Date Prescription Written
8. Directions for Use	9. Start Date Requested

10. Name — Prescriber	11. National Provider Identifier (NPI) — Prescriber

12. Address — Prescriber (Street, City, State, ZIP+4 Code)

13a. Telephone Number — Prescriber

13b. In case the PA consultant needs additional information about the child, provide a contact person's name and telephone number at the clinic where the child was seen who can be contacted to discuss the child's clinical information.

SECTION III — DIAGNOSIS INFORMATION

14. Diagnosis Code and Description

Continued

DT-PA101-101

SECTION III — DIAGNOSIS INFORMATION (Continued)

15. Indicate whether or not the child has one of the following conditions:

01. Autism ❒ Yes ❒ No

02. Tics ❒ Yes ❒ No

Prescriber Responsibilities

Prescribers should do the following:

- If the response to either condition in Element 15 is yes, no additional clinical information is required on this form; the prescriber should skip to Section XI (Authorized Signature) and sign and date this form.
- If the response to both conditions in Element 15 is no, the prescriber is required to complete the entire form.
- Submit the completed, signed, and dated form to the pharmacy where the prescription will be filled.

Pharmacy Responsibilities

For completed PA requests, pharmacy providers should do the following:

- If the response to either condition in Element 15 is yes, pharmacy providers are encouraged to submit this completed form to ForwardHealth using the STAT-PA system.
- If the response to both conditions in Element 15 is no, pharmacy providers should complete a Prior Authorization Request Form (PA/RF), F-11018, and submit it with this completed form to ForwardHealth on the Portal, by fax, or by mail.

SECTION III A — ADDITIONAL DIAGNOSIS INFORMATION

16. Additional Diagnosis Codes and Descriptions Related to Behavioral Health Conditions

SECTION IV — BODY MASS INDEX (BMI) INFORMATION

17. Height — Child (Inches) (Two Digits)	18. Weight — Child (Pounds) (Three Digits)	19. Date of Child's Weight Measurement (In MM/CCYY Format)
_____ _____ in	_____ _____ _____ lbs	____ ____ / ____ ____ ____ ____ (Month / Year)
20. BMI — Child _____ _____ . _____	BMI = 703 X (weight in pounds) / (height in inches)^2	21. BMI Percentile _____ _____ . _____

Note: The BMI calculation and percentile can also be calculated using *nccd.cdc.gov/dnpabmi/Calculator.aspx*.

SECTION V — CLINICAL INFORMATION FOR CHILDREN WITH A BMI PERCENTILE ≥ 85

22. List the child's most recent lipid panel, fasting glucose, and date(s) taken. (Date must be within the past six months.)

Date of Lipid Panel _____

Total Cholesterol _____

High-Density Lipoprotein (HDL) Cholesterol _____

Low-Density Lipoprotein (LDL) Cholesterol _____

Triglyceride _____

Date of Fasting Glucose _____

Fasting Glucose _____

SECTION VI — MEDICATION USE

23. Is the child currently taking the antipsychotic drug being requested? ❒ Yes ❒ No

24. Is the child currently taking a selective serotonin reuptake inhibitor (SSRI)? ❒ Yes ❒ No

Has the child taken an SSRI in the past? ❒ Yes ❒ No

Continued

SECTION VI — MEDICATION USE (Continued)

25. Indicate below the child's experience with psychoactive medication(s) other than the drug being requested. List the drugs and the highest daily doses achieved that the child is currently taking and has taken in the past in the spaces provided.

Drug Class	Current	Past
Alpha-2 Adrenergic Agonist	Name(s)	Name(s)
	Highest Daily Dose(s) Achieved	Highest Daily Dose(s) Achieved
Antidepressant	Name(s)	Name(s)
	Highest Daily Dose(s) Achieved	Highest Daily Dose(s) Achieved
Antipsychotic	Name(s)	Name(s)
	Highest Daily Dose(s) Achieved	Highest Daily Dose(s) Achieved
Stimulant	Name(s)	Name(s)
	Highest Daily Dose(s) Achieved	Highest Daily Dose(s) Achieved
Anticonvulsant / Mood Stabilizer / Lithium / All Other Drug Classes	Name(s)	Name(s)
	Highest Daily Dose(s) Achieved	Highest Daily Dose(s) Achieved

Continued

SECTION VII — ADDITIONAL CLINICAL INFORMATION

26. Indicate all of the following that apply to the child.

1. ❑ Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD).
2. ❑ Diagnosis of Oppositional Defiant Disorder (ODD).
3. ❑ Symptom of persistent irritability / anger (daily or nearly daily).
4. ❑ Symptom of temper outbursts (three or more per week).

SECTION VIII — PRESCRIBER SPECIALTY INFORMATION

27. Indicate the specialty of the prescribing provider. If other, indicate the specific specialty in the space provided.

1. ❒ Child Psychiatrist Board Certified.
2. ❒ Child Psychiatrist Board Eligible.
3. ❒ Developmental-Behavioral Pediatrician Board Certified.
4. ❒ Other Specialty. (Describe.) _____

SECTION IX — DOCUMENTATION FOR A NON-PREFERRED ANTIPSYCHOTIC DRUG (This section does not need to be completed if the drug being requested is a preferred antipsychotic drug on the ForwardHealth Preferred Drug List [PDL].)

28. Has a preferred antipsychotic drug(s) been attempted in the past? ❑ Yes ❑ No

If yes, indicate the following details in the spaces provided.

Preferred Antipsychotic Drug(s) _____

Highest Daily Dose(s) Achieved _____

Length of Treatment(s) _____

Approximate Date of Trial(s) _____

If yes, also provide detailed reasons why the preferred drug(s) was discontinued.

Clinical Documentation (Enter in the space provided.)

If no, provide detailed reasons why the child is unable to take a preferred drug(s).

Clinical Documentation (Enter in the space provided.)

Continued

SECTION X — FOR PHARMACY PROVIDERS USING STAT-PA

29. NDC (11 Digits)	30. Days' Supply Requested

31. NPI

32. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

33. Place of Service

34. Assigned PA Number	35. Grant Date	36. Expiration Date

SECTION XI — AUTHORIZED SIGNATURE

37. **SIGNATURE** — Prescriber	38. Date Signed

SECTION XII — ADDITIONAL INFORMATION

39. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may be included here.

Reset Form