DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00556 (03/14)

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

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 member, provide a contact person's name and telephone number at the clinic where the member was seen who can be contacted to discuss the member's clinical information.

SECTION III — DIAGNOSIS INFORMATION

14. Diagnosis Code and Description

Diagnosis Code

Diagnosis Code Description_____

SECTION IV — TARGET SYMPTOMS

15. Check the **one** target symptom cluster that applies to this child. (Do not check more than one target symptom.) If other, indicate the specific target symptom(s) in the space provided.

01. ❒ Mood-Related Irritability.
02. ❒ Aggression / Anger / Temper Tantrums / Defiance.
03. ❒ Other Target Symptom(s). _____

Continued

SECTION V — CLINICAL INFORMATION FOR STIMULANT USE (INCLUDING STRATERRA)

16. Is the child currently taking a stimulant medication (including Straterra)? ❑ Yes ❑ No

SECTION VI — BODY MASS INDEX (BMI) INFORMATION

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

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

SECTION VII — 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 VIII — CURRENT MEDICATION USE

23. Is the child currently taking a psychoactive medication(s) other than the drug being requested? ❑ Yes ❑ No

If yes, check the medication category(s); indicate the name of the drug(s) and the total daily dose in the space provided. Check all categories that apply.

❑ Alpha-2 Adrenergic Agonist.
Drug Name _____ / Total Daily Dose _____

❑ Anticonvulsant / Mood Stabilizer.
Drug Name _____ / Total Daily Dose _____

❑ Antidepressant.
Drug Name _____ / Total Daily Dose _____

❑ Antipsychotic.
Drug Name _____ / Total Daily Dose _____

❑ Lithium.
Drug Name _____ / Total Daily Dose _____

❑ Stimulant.
Drug Name _____ / Total Daily Dose _____

❑ Other.
Drug Name _____ / Total Daily Dose _____

24. Is the child currently taking the antipsychotic drug being requested? ❑ Yes ❑ No

Continued

SECTION IX — PAST MEDICATION USE

25. Has the child previously (within the last 12 months) taken a psychoactive medication(s) that he or she is no longer taking? ❑ Yes ❑ No

If yes, check the medication category(s), and indicate the name of the drug(s) and total daily dose in the space provided. Check all categories that apply.

❑ Alpha-2 Adrenergic Agonist.
Drug Name _____ / Total Daily Dose _____

❑ Anticonvulsant / Mood Stabilizer.
Drug Name _____ / Total Daily Dose _____

❑ Antidepressant.
Drug Name _____ / Total Daily Dose _____

❑ Antipsychotic.
Drug Name _____ / Total Daily Dose _____

❑ Lithium.
Drug Name _____ / Total Daily Dose _____

❑ Stimulant.
Drug Name _____ / Total Daily Dose _____

❑ Other.
Drug Name _____ / Total Daily Dose _____

SECTION X — PRESCRIBER SPECIALTY INFORMATION

26. 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 XI — CONSULTATION HISTORY (This section does not need to be completed if the prescriber completing the form is a child psychiatrist.)

27. Has the child ever received a child psychiatry consultation? ❑ Yes ❑ No

If yes, indicate what type of consultation the child received, the name of the consultant, and the date of the consultation in the space provided.

A. ❑ Child seen formally.
B. ❑ Child not seen formally (e.g., medical record review, telephone consultation).

Name — Consultant _____

Date of Consultation _____

Continued

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

28. If the drug being requested is a non-preferred antipsychotic drug on the ForwardHealth Preferred Drug List, has a preferred antipsychotic drug(s) been attempted in the past? ❑ Yes ❑ No

Indicate the preferred antipsychotic drug(s), date of the trial(s), and clinical justification why a non-preferred antipsychotic drug is necessary over a preferred antipsychotic drug in the space provided.

Preferred Antipsychotic Drug(s) _____

Date of Trial(s) _____

Clinical Justification (Enter in the space provided.)

SECTION XIII — 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 XIV — AUTHORIZED SIGNATURE

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

SECTION XV — 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