**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services Wis. Admin. Code § DHS 107.10(2)

F-00556 (01/2018)

**FORWARDHEALTH**

**PRIOR AUTHORIZATION DRUG ATTACHMENT**

**FOR ANTIPSYCHOTIC DRUGS FOR CHILDREN 8 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 8 Years of Age and Younger 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](http://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 8 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.

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| **SECTION I – MEMBER INFORMATION** | | | |
| 1. Name – Member (Last, First, Middle Initial) | | | |
| 2. Member ID 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 | | | |

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| **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)        in | 18. Weight – Child (Pounds) (Three Digits)        lbs | 19. Date of Child’s Weight Measurement (In MM/CCYY Format)  Month / Year  Month Year |
| 20. BMI – Child        . | BMI = 703 X (weight in pounds)  (height in inches)2 | 21. BMI Percentile        . |
| *Note:* The BMIcalculation and percentile can also be calculated using [nccd.cdc.gov/dnpabmi/Calculator.aspx](https://nccd.cdc.gov/dnpabmi/Calculator.aspx). | | |
| **SECTION V – CLINICAL INFORMATION FOR CHILDREN WITH A BMI PERCENTILE ≥ 85** | | |
| 22. List the child’s most recent triglyceride level, fasting glucose or hemoglobin A1c (HBA1c), and date(s) taken. (Date must be within the past **six** months.)  Triglyceride Level  Date of Triglyceride Level  Fasting Glucose **or** HBA1c  Date of Fasting Glucose or HBA1c | | |
| **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 | | |

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| **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 |
| **SECTION VII – ADDITIONAL CLINICAL INFORMATION** | | |
| 26. Indicate if the child has the following symptoms.  1. Symptom(s) of persistent irritability / anger (daily or nearly daily)  Yes  No  2. Symptom(s) of temper outbursts (three or more per week).  Yes  No  3. Symptom(s) of anxiety.  Yes  No  If yes to symptoms of anxiety, describe below. | | |

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| **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 the member experienced an unsatisfactory therapeutic response or a clinically significant adverse drug reaction with at least one of the  preferred drugs from the same PDL drug class as the drug being requested?  Yes  No  If yes, list the preferred drug(s) used.  List the dates the preferred drug(s) was taken.  Describe the unsatisfactory therapeutic response(s) or clinically significant adverse drug reaction(s) in the space below. |

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| **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. | | | | |