Prior Authorization Request
Nevada Medicaid – Molina Healthcare

Psychotropic Agents for Children Age 0 to 5

Please provide the information below. Please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

DATE OF REQUEST:

MEMBER INFORMATION

Name:	DOB:	Molina ID:

PRESCRIBING PROVIDER INFORMATION

Name:	NPI:	Specialty:
Contact person for request:	Fax (required):	Phone:

REQUESTED DRUG

Drug Name:	Strength:	Dosage:	Duration:

☐ Medication is an anticonvulsant used to treat a seizure disorder – No further documentation required.
☐ The request is for **initiation of therapy** (recipient has not started therapy).
☐ The request is for **continuation of therapy.**
☐ The recipient is currently stabilized on the requested medication.
☐ Recipient was recently discharged (within 30 days) from an institutional facility on the requested medication; **if yes, document:** the name of the facility:_____and date of discharge: _____

TREATMENT DIAGNOSIS

Diagnosis or Diagnosis Code (list ONE only):_____
☐ Peer-reviewed literature/citation has been included if the requested agent is not FDA-approved for the specific diagnosis.

PSYCHOTROPIC AGENTS CURRENTLY PRESCRIBED

Drug:	**Treatment Diagnosis:**	**Target Symptom and/or side-effect:**

PRIOR AUTHORIZATION CRITERIA (Per MSM Chapter 1200)

A. Each requested agent must be independently treating a specific symptom and/or diagnosis.

For polypharmacy requests treating the same diagnosis; document the specific target symptom or side-effect:

Target symptoms:	☐ Psychosis	☐ Depression	☐ Anxiety	☐ Inattentiveness
	☐ Impulsivity	☐ Irritability	☐ Aggression	☐ Oppositional
Target side effects:	☐ Sedation	☐ Restlessness	☐ Other Dyskinesia	☐ Stiffness
	☐ Dystonia	☐ Tremor		

Other ☐ symptom or ☐ side-effect: _____

B. When medication used to **augment** the effect of another psychotropic for the same diagnosis, the recipient's medical record must clearly document the purpose of the poly-pharmacy.
Purpose: _____

C. Recipient will be cross-tapered with the requested agent with a 30-day cross-taper and the previously prescribed agent will be discontinued.
☐ **Agent to be discontinued**: _____

D. Multiple agents within the same class (Intra-class) - The recipient must have a trial of each individual medication alone.
☐ The recipient has inadequate response to monotherapy.
Justification for additional agent:_____

ADDITIONAL INFORMATION

Please document any additional information for consideration *(intra-class polypharmacy or previous agents tried and failed):*

PREFERRED DRUG LIST CRITERIA - *Required for requested agents that are non-preferred.*

A copy of the Preferred Drug List (PDL) can be found at: medicaid.nv.gov/providers/rx/pdl.aspx

☐ The recipient has allergy(ies) to ALL preferred medications; **document each reaction below.**

☐ The recipient has a contraindication(s) to ALL preferred medications; **document each contraindication below.**

☐ The recipient has a drug-to-drug interaction(s) with ALL preferred medications; **document each interaction below.**

☐ The recipient has had therapeutic failure with at least two preferred psychotropics or, if the request is for an antipsychotic, the recipient has had therapeutic failure with at least one preferred antipsychotic; **document each agent below.**

☐ The requested agent is being used for an indication which is unique to a non-preferred agent and is supported by peer-reviewed literature or an FDA-approved indication. Citation:_____

Document each agent from the above section or any other agents previously tried and failed.

Drug:	Reason:	Date(s) of Trial:

COVERAGE AND LIMITATIONS *(Per MSM Chapter 1200)*

For All Requests:

A. When possible, the requested agent is prescribed by or in consultation with a child psychiatrist.
B. Recipient has a comprehensive treatment plan that addresses education, behavioral management, living home environment and psychotherapy.
C. The recipient will be monitored by the prescriber at least monthly (recipient is unstable).
D. The recipient will be monitored by the prescriber at least every three months (recipient is stable).

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature:_____ **Date:** _____

This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.