If the following information is not complete, correct, or legible, the PA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

MOLINA ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ Male ☐ Female

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

DIAGNOSIS AND MEDICAL INFORMATION

Antipsychotics in children younger than 18 years old—to receive approval for this drug, complete the following questions.

Indicate the diagnoses being treated (include ALL ICD codes, if applicable):

_____

_____

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Member's Last Name: **Member's First Name:**

Does the member meet the following criteria?

1. **Is the prescribing provider a psychiatrist, neurologist, or developmental/behavioral pediatrician?**
   ☐ Yes ☐ No
   If YES, document the specialty: _____
   If NO, has the provider consulted with a psychiatrist, neurologist, or developmental/behavioral pediatrician before prescribing the requested medication?
   ☐ Yes ☐ No
   If YES, date of consult: _____

2. **Has the member 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 ☐ Other reason: _____

3. **Is psychosocial treatment in place without adequate clinical response and will psychosocial treatment with parental involvement continue for the duration of medication therapy?**
   ☐ Yes ☐ No

4. **Has informed consent for this medication been obtained from the parent or guardian for label and/or off-label use?**
   ☐ Yes ☐ No

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

6. **Is this continuation of therapy?**
   ☐ Yes (please provide pertinent clinical details and rationale for therapy)
   ☐ No

7. **Is this continuation of therapy beginning in-patient hospitalization?**
   ☐ Yes (please provide dates) ☐ No

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Member's Last Name:

Member's First Name:

List pharmaceutical agents attempted and outcome:

Prescriber signature (required)

Date

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **FAXED to 1-844-278-5731**, or you may call **(800) 424-4518 (TTY: 711)**

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