Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Antipsychotic Agents Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Antipsychotic Agents.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Is the provider a Psychiatrist, Neurologist, or Developmental/Behavioral Pediatrician or has the provider consulted with one of these specialists prior to prescribing the requested agent? □ No □ Yes

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:

□ Initial Request □ Continuation of Therapy Request

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5 – Diagnosis

Diagnosis: _____

6 – Clinical Criteria

Is the patient ≤ 17 years old?
□ Yes □ No; if No, Prior Authorization is not required

Attestation of Required Documentation within Patient Chart (check each as completed):

□ Developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, goals, and plan

□ Psychosocial treatment without adequate clinical response

□ Current or previous pharmacological agents used with clinical outcomes for each

□ Assessment of family-functioning and parent/guardian-child relationship, including parental/guardian psychopathology

□ Proposed treatment plan including psychosocial therapy with parental/guardian involvement for the duration of therapy

□ Informed consent for this medication from the parent/guardian

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**