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SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Medicaid Program

Prior Authorization Request Form

Antipsychotics – Children ≤ 6 Years

Form must be complete, correct, and legible or the PA process can be delayed.

Request Date: ___ / ___ / _____

I. BENEFICIARY INFORMATION

First Name | **Last Name**

Medicaid ID # | **Date of Birth (MM/DD/YYYY)** | **Sex** ☐ Male ☐ Female

II. PRESCRIBER'S INFORMATION

Prescriber's First Name | **Prescriber's Last Name**

National Provider ID # (NPI) | **Prescriber's Specialty**

Prescriber's Phone Number | **Prescriber's Fax Number**

Prescriber's Office Staff Member Completing This Form

Pharmacy | **Phone**

III. DRUG INFORMATION

Drug Name: _____ **Dose:** _____ **Strength:** _____ **Duration:** _____

Dosage Schedule: _____

Diagnosis: _____ **ICD Code:** _____

1. **Is the Prescriber a Psychiatrist? Or, has the Prescriber consulted with a Psychiatrist before requesting this medication?** ☐ Yes ☐ No
2. **Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target and treatment plans clearly identified and documented?** ☐ Yes ☐ No
3. **Has informed consent for this medication been obtained from the parent or guardian?** ☐ Yes ☐ No
4. **Has a family assessment been performed (including parental psychopathology and treatment needs) and have family functioning and parent-child relationship been evaluated?** ☐ Yes ☐ No
5. **Psychosocial treatment has been in place for at least 12 weeks without adequate clinical response and psychosocial treatment with parental involvement will continue for the duration of medication therapy.** ☐ Yes ☐ No
   Select YES, if this statement is true.
6. **Is the requested medication the only antipsychotic medication the patient will be receiving?** ☐ Yes ☐ No
   6a. **If NO to the question above, is one agent being tapered while titrating another?** ☐ Yes ☐ No
7. **Is this request for continuation of an established therapy? Or, for continuation of therapy initiated during an in-patient hospitalization?** ☐ Yes ☐ No
   7a. **If YES to the question above, please document the specific medication:** _____
8. **If Tourette's is listed as the diagnosis, please answer the following questions:**
   8a. **Has the patient failed treatment with previous therapy (such as clonidine or guanfacine)?** ☐ Yes ☐ No
   8b. **If YES to the question above, please document the specific medication:** _____

PRESCRIBER'S SIGNATURE: _____ **DATE** _____

Fax completed forms to Magellan Rx Management.
All fax requests will be processed in one business day.
To check the status of your request, please call or visit our website.
Revised: September 2015

Fax: 888-603-7696
Phone: 866-247-1181
Website: http://southcarolina.fhsc.com/

Magellan Rx MANAGEMENT℠