Aetna Better Health® of Florida (MEDICAID)

Antipsychotic (< 6 years of age)

180-day Maximum Approval

Note: Form must be completed in full.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ___

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number ___ - ___ - ___

Prescriber's Fax Number ___ - ___ - ___

PROVIDER TYPE OR SPECIALTY: _____ **CHILD UNDER STATE CARE/CUSTODY:** ☐ Yes ☐ No

PATIENT: ☐ Male ☐ Female **MEDICATION REQUEST:** ☐ New ☐ Continuation

HEIGHT: _____ ☐ in / ☐ cm **WEIGHT:** _____ ☐ lbs / ☐ kgs **BMI:** _____ ***BMI %:** _____

BMI Calculator: * https://www.cdc.gov/healthyweight/bmi/calculator.html

Antipsychotic Medication/Strength:

_____

Quantity: _____

Directions:

_____

_____

Target Symptoms: (check all that apply)
- ☐ Aggression
- ☐ Self-Injurious Behavior
- ☐ Impulsivity
- ☐ Irritability
- ☐ Other

_____

_____

Diagnosis:
- ☐ ADHD
- ☐ Autism Spectrum
- ☐ Disruptive Behavior Disorder
- ☐ Disruptive Mood Dysregulation Disorder
- ☐ Other

_____

_____

Severity of Target Symptoms ☐ 1 Mild ☐ 2 Moderate ☐ 3 Marked ☐ 4 Severe ☐ 5 Extreme

Functional Impairment: ☐ 1 Mild ☐ 2 Moderate ☐ 3 Marked ☐ 4 Severe ☐ 5 Extreme

Previous Therapy (Pharmacological and Non Pharmacological):

_____

_____

Have metabolic monitoring labs* (fasting lipids and glucose) been performed within the last 6 months?: ☐ Yes ☐ No

**Official lab results (most recent) must be attached. For continuation of therapy, labs are required.* Date:_____

Has an assessment for Tardive Dyskinesia been done in the last 6 months? **AIMS**: ☐ Yes ☐ No **DISCUS**: ☐ Yes ☐ No

**Official Form or notation (most recent) must be attached.* Date: _____

Monitoring Plan: RTC: _____ Labs: q _____ months TD Screen: q _____ months

Next appointment date: _____

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

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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Review Criteria

- The most current antipsychotic prior authorization request form is required for review.
- All relevant sections of the antipsychotic prior authorization form must be complete.
- To calculate the BMI and BMI percentile, the Centers for Disease Control and Prevention (CDC) provides a **BMI Calculator for Children and Teens** that may be accessed at the following link: https://www.cdc.gov/healthyweight/bmi/calculator.html
- The evaluation and progress notes must document target symptoms and behaviors.
- Continuation requests require documentation to demonstrate monitoring for movement disorders. Find screening tools (AIMS, DISCUS) at: http://floridabhcenter.org/assessment-scales.html
- Continuation requests require the attachment of the most recent metabolic monitoring labs to include
  - Fasting glucose and fasting lipids.

Clinical Notes

- Psychosocial treatments should precede the use of psychotherapeutic medications and should continue if medications are prescribed.
- Risks and benefits should be carefully considered before prescribing an antipsychotic.
- Prior to starting an antipsychotic medication, baseline measures should be obtained for weight, height, BMI, blood pressure, fasting glucose and fasting lipids.
- Assessments obtained at baseline should be repeated at three months and at least annually to assure safety and efficacy with the use of antipsychotic treatment.
- Fasting glucose and lipids may need to be assessed every six months to provide optimal monitoring in young children.
- Assessment for movement disorders should be performed during the initial titration, at three months and annually.

Florida Medicaid Clinical Guidelines

Access the following guidelines at http://floridabhcenter.org/index.html:

- *Principles of Practice Regarding the Use of Psychotropic Medication in Children Under Age 6*
- *Florida Medicaid Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents*