Updated: 05/2024
DMMA Approved: 06/2024

Request for Prior Authorization for Antipsychotics for Children Younger than 18 Years of Age

Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Antipsychotics for Children Younger than 18 Years of Age require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Antipsychotics for Children Younger than 18 Years of Age Prior Authorization Criteria:

Transition-in-care provision: Members who are requesting continuation of therapy but do not meet all criteria below will be approved for 6 months to avoid disruption of care and allow time to obtain the required information below

For all requests for antipsychotics for children younger than 18 years of age all of the following criteria must be met:

- Coverage may be provided when there is documented evidence of severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses:
  - Autism Spectrum Disorder
  - Intellectual disability
  - Conduct Disorder
  - Bipolar Disorder
  - Tic Disorder, including Tourette's Syndrome
  - Transient encephalopathy
  - Schizophrenia
- Medication is prescribed by, or in consultation with, an appropriate specialist including:
  - Pediatric Neurologist
  - Child and Adolescent Psychiatrist
  - Child Development Pediatrician
  - Psychiatric Mental Health Nurse Practitioner (PMHNP)
  - Adult Psychiatrist when the member is at least 14 years of age
  - Adult Psychiatrist prescribing in conjunction with one of the specialists above for members younger than 14 years of age
- Chart documented evidence is provided of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above, including documentation that non-pharmacologic therapies such as, but not limited to, evidence based behavioral, cognitive and family based therapies have been tried
- The member has documentation of all of the following measurements within the past year:
  - Weight or body mass index (BMI)
  - Blood pressure
  - Fasting glucose
  - Extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)
  - Fasting lipid panel

- If the request is for a new start, the following additional criteria must be met:
    - For non-preferred antipsychotics, the member has tried and failed two preferred antipsychotics
    - For injectable antipsychotics, all of the following must be met:
        - Documentation the member has tolerated a previous trial of the oral dosage form for the atypical antipsychotic requested or on a medication which metabolizes into an active metabolite of requested medication.
        - For agents administered less frequently than monthly, the member has been stabilized on the minimum number of monthly injections with adequate response and patient tolerance (per prescribing information)
        - Age, dosage, frequency, and dose initiation conversions between different formulations must be within the FDA-approved range
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation of all of the following:
        - Improvement in target symptoms
        - Has a documented plan for taper/discontinuation of the antipsychotic or rationale for continued use
        - Chart information supporting annual monitoring of the following:
            - Weight or BMI
            - Blood pressure
            - Glucose
            - Lipids
            - EPS using AIMS
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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ANTIPSYCHOTICS FOR CHILDREN YOUNGER THAN AGE 18
PRIOR AUTHORIZATION FORM – PAGE 1 of 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon-Fri 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Autism ☐ Intellectual disability ☐ Conduct Disorder ☐ Bipolar ☐ Schizophrenia
☐ Tic Disorder/Tourette's ☐ Transient encephalopathy ☐ Other:_____ICD-10:_____

Is this medication being prescribed by or in consultation with one of the following specialists?
☐ Pediatric Neurologist ☐ Child and Adolescent Psychiatrist ☐ Child Development Pediatrician
☐ Adult Psychiatrist ☐ Psychiatric Mental Health Nurse Practitioner ☐ Other: _____

Is there chart documented evidence of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above that describes <u>severe behavioral problems related to the diagnosis</u>? *Documentation must be provided via a fax attachment to this request.* ☐ Yes, documentation is attached ☐ No

Member must have tried one of the therapies listed below in the last 6 months (check all that apply):
☐ Cognitive therapy ☐ Evidence-based behavioral therapy ☐ Family-based therapy ☐ Other:

Has the member had monitoring of weight, blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)? ☐ Yes, documentation is attached ☐ No

FOR INJECTABLES:
Has the member tolerated a trial of the oral dosage form for the medication requested? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

Continued on next page

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ANTIPSYCHOTICS FOR CHILDREN YOUNGER THAN AGE 18
PRIOR AUTHORIZATION FORM (CONTINUED) – PAGE 2 OF 2

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:00am to 7:00pm

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REAUTHORIZATION

Has the member shown improvement in target symptoms? ☐ Yes ☐ No
Please describe:

Please provide rationale for continued use of the antipsychotic OR a plan for taper/discontinuation:
☐ Rationale for continued use: _____
☐ Plan for taper/discontinuation:

Has the member had follow-up monitoring of weight, blood pressure, glucose, lipids, and EPS using AIMS?
☐ Yes, documentation is attached ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date