Updated: 05/2019
PARP Approved: 07/2019

Prior Authorization Criteria

Antipsychotics for Children Younger than 18 Years of Age

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:

- 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
  - General Psychiatrist when the member is at least 14 years of age
- Chart documented evidence is provided of a comprehensive evaluation 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 baseline measurements:
  - 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 a non-formulary oral atypical antipsychotic, the member has tried and failed two formulary oral atypical antipsychotics
  - For Latuda, the member has tried and failed one generic formulary oral atypical antipsychotic
  - For clozapine, the member has tried and failed at least two other oral antipsychotics
  - For an injectable, there is evidence tolerability has been established with an oral antipsychotic prior to initiation of an injectable antipsychotic **AND** there is evidence describing compliance concerns with daily oral dosage forms of antipsychotics
- **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 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

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ANTIPSYCHOTICS FOR CHILDREN YOUNGER THAN AGE 18
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a 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
☐ General Psychiatrist ☐ Other: _____

Is there chart documented evidence of a comprehensive evaluation 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

Please indicate the non-pharmacologic therapies that have been tried (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
- Are there issues with compliance of oral dosage forms? ☐ Yes, please explain below ☐ No

CURRENT or PREVIOUS THERAPY

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

Continued on next page

Gateway Health

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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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

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