



**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

Standard Review (72 hours)

Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature _____

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:

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility