CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 2000**3**
www.carefirstchpdc.com

Prior Authorization Request Form
Antipsychotics for Children < 18 Years

Phone: 1-866-287-6156 | Fax: 1-866-839-2372 | www.carefirstchpdc.com
Monday – Friday: 8:00 AM to 4:30 PM

Coverage Policy: Coverage of antipsychotics in the treatment children will be provided when ALL of the following conditions are met:

- Psychosocial therapies were implemented before the use of antipsychotics. An explanatory rationale is required if these were not implemented.
- Psychosocial therapies will accompany pharmacotherapy.
- Rationale for administration is based on analysis of risks versus benefits of antipsychotic treatment.
- Baseline lab measurements have been obtained before treatment and will be repeated according to medical standards throughout therapy.

****All fields must be complete and legible for review****
Prior authorizations cannot be completed over the phone.

Patient Information	Provider Information
Patient Name:	**Provider Name:**
Member ID#:	**NPI:**
Date of Birth:	**Office Phone: ( )**
Phone:	**Office Fax: ( )**
Drug Allergies:	**Office Street Address:**

General Information

Requested Medication:	**Strength:**	**Dosage form:**	**Quantity:**
	Directions:		**Requested length of therapy:**

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

Trusted Health Plan (District of Columbia), Inc. doing business as CareFirst BlueCross BlueShield Community Health Plan District of Columbia is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

IMPORTANT: This facsimile transmission may contain confidential information, some or all of which may be protected health information as defined by federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule (45 C.F.R. Part 160; Subparts A and E of Part 164). This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent for delivering this to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone at: 1-866-287-6156 to arrange the return or destruction of the information and all copies.

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

ABARCA

General Information

Are any other psychotropics being used concurrently *(Please indicate)*: ☐ **No** ☐ **Yes:** _____ _____	**Medication Request:** ☐ **New** ☐ **Continuation** **Is prescriber a specialist:** ☐ **Yes** ☐ **No** **If prescriber is not a specialist has prescriber consulted with one of the listed specialists:** ☐ **Yes** ☐ **No**	**Please indicate specialty:** ☐ **Pediatric Neurologist** ☐ **Child and Adolescent Psychiatrist** ☐ **Child Developmental/Behavioral Pediatrician** ☐ **Other:** _____

Clinical Information

Diagnosis:	**ICD-10 Codes(s):**
Target Symptoms (*ex aggression, hyperactivity, irritability, etc***). :**	

Baseline Monitoring Conducted:

☐ **No labs have been conducted** ☐ **Lab values will be marked below** ☐ **Lab report attached**

Lab Values:

Date of labs: _____

☐ **Weight:** _____

☐ **BMI:** _____

☐ **Fasting glucose:** _____

☐ **Blood pressure:** _____

☐ **Fasting lipid panel**

☐ **Movement disorder scale (AIMS / DISCUS)** *(Please attach)*

DHCF GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR
This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

Trusted Health Plan (District of Columbia), Inc. doing business as CareFirst BlueCross BlueShield Community Health Plan District of Columbia is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

IMPORTANT: This facsimile transmission may contain confidential information, some or all of which may be protected health information as defined by federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule (45 C.F.R. Part 160; Subparts A and E of Part 164). This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent for delivering this to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone at: 1-866-287-6156 to arrange the return or destruction of the information and all copies.

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 2000**3**
www.carefirstchpdc.com

CareFirst Community Health Plan District of Columbia

ABARCA

Psychosocial Therapy Interventions

Is there a plan for psychosocial intervention? Please describe. (*Supporting clinical documentation may be attached*)

If yes, please provide details of the plan:

If no, please explain why not:

Additional Information

Please provide rationale and medical necessity behind the use of the requested medication if it varies from FDA approved indications/dosing. (*Supporting clinical documentation may be attached*)

By signing, this signature certifies that all the information provided on this request is complete and factual.

Physician Signature: _____ **Date Signed: _____**

DHCF GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR
This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

Trusted Health Plan (District of Columbia), Inc. doing business as CareFirst BlueCross BlueShield Community Health Plan District of Columbia is an independent licensee of the Blue Cross and Blue Shield Association. The Blue Cross® and Blue Shield® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

IMPORTANT: This facsimile transmission may contain confidential information, some or all of which may be protected health information as defined by federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule (45 C.F.R. Part 160; Subparts A and E of Part 164). This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent for delivering this to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone at: 1-866-287-6156 to arrange the return or destruction of the information and all copies.