Print Form Reset Form

Florida Medicaid Prior Authorization
Antidepressant < 6 years
Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number

Prescriber 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: * http://nccd.cdc.gov/dnpabmi

Medication:	**Strength:**	**Quantity:**	**Directions (with titration or taper if indicated):**

Target Symptoms (Check all that apply.):
- ☐ Depressive, Sad Mood or Anhedonia
- ☐ Irritability
- ☐ Somatic Complaints
- ☐ Appetite Disturbances
- ☐ Sleep Disturbances
- ☐ Anxiety
- ☐ Obsessions and/or Compulsions
- ☐ Aggression or self-injurious behavior
- ☐ Other: _____

Diagnosis:
- ☐ Major Depressive Disorder
- ☐ Disruptive Mood Dysregulation Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Generalized Anxiety Disorder
- ☐ Post-Traumatic Stress Disorder
- ☐ Panic 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) including Effectiveness/Tolerability/Compliance:

NEXT APPOINTMENT DATE: _____

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____

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

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727

University of South Florida, School of Medicine, Department of Psychiatry

USF Child Psychiatrist Review:

○ I do not recommend approval ○ I recommend approval for _____ months

USF Child Psychiatrist Signature: _____ Date: _____

Review Criteria:

- The most current antidepressant prior authorization request form is required for review.
- All relevant sections of the antidepressant prior authorization form must be complete.
- The evaluation and progress notes must document target symptoms and behaviors.

Clinical Notes:

- Psychosocial treatments (e.g., dyadic therapy) must precede the use of psychotherapeutic medications and should continue if medications are prescribed.
- Risks and benefits should be carefully considered before prescribing an antidepressant.
- When discontinuing antidepressant medication prescribed for depression or anxiety, gradually taper down the dose to prevent discontinuation syndrome.

Calculation of 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 link below:

http://apps.nccd.cdc.gov/dnpabmi/Calculator.aspx?CalculatorType=Metric

Florida Medicaid Clinical Guidelines:

- Access the Principles of Practice for children younger than 6 years of age at: http://medicaidmentalhealth.org/ViewGuideline.cfm?GuidelineID=32
- Access the complete Florida Medicaid Psychotherapeutic Medication Treatment Guidelines on the Web at: http://medicaidmentalhealth.org/