



FLORIDA MEDICAID PRIOR AUTHORIZATION

Antidepressant < 6 years

Note: Form must be completed in full.

Recipient's Medicaid ID#

Grid for Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber's Phone Number

Grid for Prescriber's Phone Number

Prescriber's Fax Number

Grid for Prescriber's 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: * https://www.cdc.gov/healthyweight/bmi/calculator.html

Table with 4 columns: 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: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Mail or Fax Information to: Magellan Medicaid Administration, Inc. Prior Authorization P. O. Box 7082 Tallahassee, FL 32314-7082 Phone: 877-553-7481 Fax: 877-614-1078



FLORIDA MEDICAID PRIOR AUTHORIZATION

Antidepressant < 6 years

Note: Form must be completed in full.

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 following link: <https://www.cdc.gov/healthyweight/bmi/calculator.html>

Florida Medicaid Clinical Guidelines:

Access the following guidelines at <http://floridabhcenter.org/index.html>

- *Principles of Practice Regarding the Use of Psychotropic Medication in Children Under Age 6*
- *Florida Medicaid Best Practice Psychotherapeutic Medication Guidelines for Children and Adolescents*

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (via return fax) immediately and arrange for the return or destruction of these documents. Distribution, reproduction or any other use of this transmission by any party other than the intended recipient is strictly prohibited.