Mountain-Pacific Quality Health

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Initial Form
Montana Healthcare Programs Prior Authorization and Informed Consent Form For use of ATYPICAL ANTIPSYCHOTIC MEDICATION IN CHILDREN ≤7 years

Member Information	Prescriber Information
Name:	Name:
DOB:	Specialty:
Member ID #:	Phone:
Date:	Fax:

Medication Requested:	Strength(mg):	Directions:
Diagnosis(es):		
Treatment goals:		

Medication List (list previously trialed and current medications):

Medication	Response	Current?
		Y/N
		Y/N
		Y/N
		Y/N
		Y/N

Has the member been evaluated by a *psychiatrist* and received a developmentally appropriate, comprehensive assessment with diagnoses, impairments, treatment target and treatment plans clearly identified?

☐ YES ☐ NO

✓ If yes, note who performed the assessment and date: _____
✓ If no, please explain: _____

Is the member being discharged from hospital/institution on this medication? ☐ YES ☐ NO

✓ If yes, name of institution and provider: _____

Required Baseline Metabolic Lab Monitoring *(initial approval will **NOT** be granted unless completed)*

1. HbA1c (date drawn) _____ OR fasting plasma glucose (date drawn)_____

Note: Even in the absence of inpaired fasting glucose, HbA1c may predict future risk of Type II Diabetes Mellitus.

2. Lipid Panel (date drawn) _____

Note: Also required at three-months and annually thereafter. Please consult individual package inserts for additional monitoring recommendations.

List Any Other Pertinent Labs Performed and Dates:

Lab:	Date:

Physical Assessment:

Has a physical assessment been performed, including height/weight, blood pressure, body mass index (BMI) and waist circumference? ☐ YES ☐ NO

American Diabetes Association & American Psychiatric Association Monitoring Recommendations for Metabolic Syndrome

Metabolic Monitoring Recommendation for Patients on Antipsychotics

Parameter Monitored	Initiation				Ongoing		
	Baseline	4 Weeks	8 Weeks	12 Weeks	Quarterly	Every 6 Months	Annually
Personal/Family History	X						X
Weight & BMI	X	X	X	X	X		
Waist Circumference	X			X			X
Blood Pressure	X			X			X
Fasting Plasma Glucose/HbA1c	X			X		x*	X
Fasting Lipid Profile	X			X		x*	X

"X" indicates adaptation from: American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes. Diabetes Care. 2004;27(2).

"x*" indicates recommendation from: Manu P,et al. Prediabetic increase in hemoglobin A1c compared with impaired fasting glucose in patients receiving antipsychotic drugs. European Neuropsychopharmacology. 2012.

Prescriber and Legal Guardian Informed Consent

I have discussed this medication and treatment plan with both the legal guardian and the recipient (if appropriate) including:

Reason for treatment, expected outcome and duration of treatment, possible side effects, monitoring requirements (labs and physical assessment), benefits vs. risk of psychotropic medications

Signature of Prescriber:_____

I consent to the use of the atypical antipsychotic listed above:

Signature of Guardian:_____ Date:_____

Please complete form and fax to: Montana Healthcare Programs Drug Prior Authorization Unit at 1-800-294-1350