

Renewal 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:
Response to medication:		

Required Metabolic Lab Monitoring (required three months after initiation and annually thereafter)

☐ Three month update
 ☐ Annual update

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

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

2. Lipid Panel (date drawn) _____

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

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