Mountain Pacific
INNOVATING BETTER HEALTH

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Renewal Form
Montana Healthcare Programs Prior Authorization and Informed Consent Form
For use of ATYPICAL ANTIPSYCHOTIC MEDICATION IN CHILDREN ≤8 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
1-800-294-1350