Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

A+KIDS: Antipsychotics for Members 17 Years of Age and Younger

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days
5. Dose Instructions: _____

Clinical Information

**** Attach Clinical Information as Needed****

For Non-Preferred Medications:

1. Has the member failed 1 preferred drug? ☐ **Yes** ☐ **No** List preferred drugs failed: _____
   a. Was the failure due to an allergic reaction? ☐ **Yes** ☐ **No**
   b. Was the failure due to a drug-to-drug interaction? ☐ **Yes** ☐ **No**
   Please describe reaction: _____
2. Was the failure due to a previous episode of an unacceptable side effect or therapeutic failure? ☐ **Yes** ☐ **No**
   Please provide clinical information: _____
3. Are there clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s)?
   ☐ **Yes** ☐ **No** Please provide clinical Information: _____
4. Are their age specific indications? ☐ **Yes** ☐ **No** Please give patient age & explain: _____
5. Is there a unique clinical indication supported by FDA approval or peer reviewed literature to support non-preferred use?
   ☐ **Yes** ☐ **No** Please explain and provide a general reference: _____
6. Is there an unacceptable clinical risk associated with associated with therapeutic change? ☐ **Yes** ☐ **No**
   Please explain: _____

Criteria for ALL medications:

7. What is the member's Primary Psychiatric diagnosis? ☐ Attention Deficit-Hyperactivity Disorder ☐ Bipolar Disorder
   ☐ Disruptive Behavior Disorder ☐ Mood Disorder-NOS ☐ Any Pervasive Development Disorder ☐ PTSD
   ☐ Schizoaffective Disorder ☐ Schizophrenia ☐ Tourette's Syndrome ☐ Other: _____
8. What is the member's target symptom? ☐ Aggression ☐ Impulsivity ☐ Inattentiveness ☐ Irritability ☐ Mania
   ☐ Oppositional ☐ Psychosis ☐ Other: _____
9. BMI: Obtained Baseline BMI ☐ **Yes** ☐ **No** BMI measured at regular intervals? ☐ **Yes** ☐ **No**
10. Labs: Obtained baseline and monitored at regular intervals:
    Glucose Level ☐ **Yes** ☐ **No** Lipid Profile ☐ **Yes** ☐ **No** Fasting Glucose ☐ **Yes** ☐ **No**
    a. If labs were not completed select one of the following reasons: ☐ Pending ☐ Not clinically indicated ☐ Unable to obtain
11. Has the member had clinical improvement since starting the Drug Treatment? Please select most appropriate:
    ☐ Modestly improved ☐ Much improved ☐ Very much improved ☐ No change ☐ Not accessed/Not applicable
    ☐ Modestly worse ☐ Much worse ☐ Very much worse
12. Adverse effects over the past week:

Daytime Sedation:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Significant restlessness:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Stiffness/Dystonia/Tremor:	☐ Mild	☐ Moderate	☐ Severe	☐ None
Other Dyskinesia:	☐ Mild	☐ Moderate	☐ Severe	☐ None

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277