



Provider for: _____
County of San Bernardino
Behavioral Health Care Services

Prior Authorization Request for Antipsychotic Prescriptions for Youth Age 17 and Younger

Prescriber Information

Prescriber Name: _____ Medical Specialty: General Psychiatry
 Child Psychiatry
 Other _____
 Agency Name: _____

Client Information

Client Name: _____ DOB: ___ / ___ / ___ Gender: _____
 Client Height: _____ inches Client Weight: _____ pounds
 History of Hospitalizations (include most recent) and past medication trials _____

Medication Request

Name of Antipsychotic Medication Requested: _____
 Diagnosis: _____ Diagnosis Code (ICD-9 or DSM-IV): _____
 Side Effects: Presence and being monitored Absence and being monitored
 Symptoms to justify antipsychotic medication: Danger to self or others Level of severe dysfunction

Psychosocial Therapy

Psychosocial interventions being received. If none, why not? _____

 Type of Therapy: Individual Family Group Other _____
 Please explain why antipsychotic medication is needed in addition to psychosocial therapy: _____

Side Effects and Metabolic Monitoring

Date of most recent lab test: _____ glucose lipid panel prolactin
 Abnormal Involuntary Movement Scale (AIMS) Completion Date: _____

Based on my current clinical judgment and client presentation, I believe that the benefits of antipsychotic treatment for this patient outweigh the risks of treatment. Benefits and risks discussed with client/family member.

Prescriber Signature: _____ Date: _____