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

Follow Up to Difficulty Experienced regarding
Prior Authorization Request for Antipsychotic Prescriptions
Youth Age 17 and Younger

Who Initiated Contact re: Difficulty with a Prior Authorization Request for Antipsychotic Prescriptions

☐ *Parent/Legal Guardian of Youth* *Name of Parent/Legal Guardian:* _____

☐ *Pharmacy* *Name of Pharmacy:* _____

☐ *Medi-Cal Insurer* ☐ *IEHP* ☐ *Molina*

☐ *Other* *Name of Caller:* _____

Agency that Caller is Affiliated: _____

Client Information

Client Name: _____ *DOB:* _____/_____/_____ *Gender:*_____

Prescriber Information

Prescriber Name: _____ *Agency:* _____

Medication Request

Name of Antipsychotic Medication Prescribed: _____

Reason for Difficulty: *Explain: Why the prescription could not be filled. What is prohibiting the TAR from being completed. Why the caller is calling.*

_____

_____

_____

_____

_____

_____

_____

_____

Printed Name of Person Responding to Call: _____

Signature: _____ *Date:* _____

When completed, please fax this form to DBH Medical Services 909-890-0435.