

**Atypical Antipsychotic Medications in Children < 8 years
Prior Authorization Request Form**

If the child is a ward of DCFS, has the physician obtained consent to prescribe this psychotropic medication from DCFS? **If not**, the prescriber must obtain consent from DCFS using the Psychotropic Medication Request form at http://www.state.il.us/DCFS/library/com_communications_forms.shtml before prescribing any psychotropic medications.

Fax completed form: 217-524-7264 **Additional information:** 800-252-8942 **To check status:** 800-642-7588

Patient Information:

Name: _____

DOB: _____

Nine-Digit HFS ID Number: _____

Prescriber Information:

Name: _____

Phone: _____ Fax: _____

Specialty: _____

Provider #: _____

Contact person for this request:

Name: _____ Phone: _____ Fax: _____

Clinical Information

1. Medication requested: _____ Dose _____ Frequency _____

2. Indication: _____

3. Describe the results of behavioral/psychosocial interventions: _____

4. If a mood stabilizer has been tried previously for this patient, please list drug and describe the results: _____

5. Please list other psychiatric illnesses that patient has been diagnosed with: _____

6. Circle **ALL** symptoms patient has **and** indicate how long they have been present.

Delusions _____ months	Grossly disorganized behavior _____ months
Disorganized speech _____ months	Catatonic behavior _____ months
Hallucinations _____ months	Severe aggression/irritability _____ months

7. Is patient being discharged from hospital or institution on this medication? Yes No

8. Other pertinent information: _____

A **Child and Adolescent Behavior Health Consultation Program** is now available for providers who wish to consult with a child and adolescent psychiatrist regarding their patients. This service is available at no charge. The hotline number is: 1-866-986-2778. The website is: www.psych.uic.edu/DOCASSIST

Prescriber or designee signature: _____

Date: _____