NEBRASKA MEDICAID PROGRAM

Additional Information for Psychotropic Requests in Children	
Use of two or more concomitant stimulants	Use of trazodone in patients under 14 years of age
	Use of trazodone > 100mg in patients < 19 yo
Use of two or more concomitant antipsychotics	Use of paroxetine and SNRIs in patients under 13 years of age
Use of two or more concomitant antidepressants	Use of stimulant in patients under 5 years of age
Use of two or more concomitant mood Stabilizers	Use of antipsychotics in patients under 6 years of Age **(Minimum age for risperidone is 5 years.)**
Use of four or more concomitant psychotropic medications	Use of antidepressants in patients under 4 years of Age
Use of two or more concomitant alpha agonists in patients under 19 years of age	Use of any mood stabilizer in patients under 4 years of age
Dose exceeds literature-based maximums for Antipsychotics	Use of eszopiclone and ramelteon in patients under 19 years of age
Dose exceeds literature-based maximums for Antidepressants	Use of alpha agonists in patients under 4 years of age
Dose exceeds literature-based maximums for atomoxetine, clonidine, guanfacine, bupropion, imipramine, or nortriptyline	Dose exceeds literature-based maximums for stimulants or other agents for ADHD

PRESCRIBING PRACTITIONER:

Name: _____
(First, Last)

Phone #: (_____) - _____

Fax #: (_____) - _____

NPI # _____

MEDICAID RECIPIENT:

Name: _____
(First, Last)

Medicaid ID#: _____

Date of Birth: __ _ /___ / _____

Patient's Weight: _____

Patient's Height: _____

PARTICIPATING PHARMACY:

Name: _____

Request Date: _____

Phone #: (_____) - _____

Fax #: (_____) - _____

Drug Name(s): _____

Strength(s): _____

Administration Schedule and expected duration of therapy: _____

_____

Requests will be forwarded to a Nebraska-Licensed, Board Certified Child and Adolescent Psychiatrist for review and determination of medical necessity. To assist the reviewing psychiatrist, the prescriber is asked to provide, to the best of his/her ability, the following information:

1. Diagnosis related to use: _____

2. Previous medications trialed for this diagnosis: _____

_____

3. Brief description of current clinical symptom(s) and impairment(s): _____

_____

4. Additional pertinent information: (please include clinical reasons for drug, relevant lab values, family history of early cardiac problems, EKG, etc.): _____

_____

_____

5. How will the patient be monitored to assure safety of requested medication, including side effects?

_____

_____

_____

6. What are the target symptoms and how will they be monitored? _____

_____

_____

7. Please attach chart notes denoting narrative patient assessment and treatment plan outlining all non-psychotherapy options tried and their outcomes. _____

_____

_____

Prescriber Signature: _____ Date: _____

(With this signature, the prescriber confirms that the information above is accurate and verifiable in patient records and the anticipated benefits outweigh the risks of treatment.)

Please note: Nebraska Total Care may request chart documentation to verify the above information. Submit requests to: Nebraska Total Care, Inc. Fax 1-866-399-0929 Tel 1-844-330-7852