COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

INFORMATION TO SUPPORT MEDI-CAL TREATMENT AUTHORIZATION REQUEST ANTIPSYCHOTICS FOR CLIENTS UNDER 18 YEARS OF AGE

(THIS IS NOT A TAR FORM)

CLIENT NAME:	**MEDI-CAL #:**	**DOB:**
REQUESTED MEDICATION (ANTIPSYCHOTIC) AND STRENGTH:		

DIAGNOSIS (DSM IV TR/ICD-10): Check primary diagnosis for antipsychotic use.	
□ 299.80 Asperger's disorder	□ 296.90 Mood disorder NOS
□ 296.80 Bipolar disorder NOS	□ 300.3 Obsessive compulsive disorder
□ 307.22 Chronic motor or vocal tic disorder	□ 299.80 Pervasive developmental disorder NOS
□ 312.9 Disruptive behavior disorder NOS	□ 298.9 Psychotic disorder NOS
□ 312.30 Impulse control disorder NOS	□ 295.90 Schizophrenia, undifferentiated
□ 312.34 Intermittent explosive disorder	□ 307.20 Tic disorder NOS
□ 296.24 Major depressive disorder, single episode, severe with psychotic features	□ **Other** (Please specify DSM IV TR/ICD-10):
□ 296.34 Major depressive disorder, recurrent, severe with psychotic features	□ **Other** (Please specify DSM IV TR/ICD-10):

JUSTIFICATION: Check all that apply.
□ FDA approved treatment (available on provided link): www.ncbi.nlm.nih.gov/books/NBK84656
□ Client has been recently discharged from hospital on this antipsychotic. Discharge date:
□ If not on an antipsychotic, client at risk of the following: □ Risk of deterioration of function leading to hospitalization. □ Risk placement in a higher level of care. □ Risk of inability to be maintained at school (e.g., Difficulty in attending/functioning in school due to severe behavioral/mood problems unless given antipsychotic). □ Risk of loss of current placement (e.g., Loss of residential or foster placement due to aggressive behavior, with history of multiple placement failures). □ Other risks (specify):
□ Risk of relapse or worsening of psychotic symptoms of not receiving antipsychotic.
□ Undesirable outcomes such as hospitalization, arrest/detention, dangerous behaviors (to self or others) that could result from not receiving of antipsychotic medication (specify outcome):
□ Failed treatment of the FDA approved medication or other first line non-antipsychotic.
□ Presence of specified relative contraindications to alternative non-antipsychotic medications that address the target diagnosis. Specify associated non-antipsychotic: Specify relative contraindications or risks:
□ Other (specify):

PRESCRIBER INFORMATION:	
NAME:	**PHONE:**
DATE:	**FAX:**