# Supplement for Antipsychotic Treatment Authorization Request (TAR) for Ages 17 Years and Younger

**PLEASE COMPLETE ALL FIELDS - (Completion of all fields is required for TAR adjudication but does not guarantee approval)**

Patient's Name: ID#: Date of Birth:

Drug Name: Dose: Directions:

If you anticipate dose titration please include the maximum quantity per month or max daily dose:

Expected Duration of Treatment in months:

Continuation therapy of medication initiated prior to release from:

Most Recent Release Date:

Type of Therapy: Diagnosis Code: ICD:

Diagnosis:

Target Symptoms:

Psycho-social Therapy:

Psychotropic Drug Therapy History:

Please indicate if the following monitoring has occurred in the preceding 12 months:

| | Y | N |
|---|---|---|
| Metobolic: | | |
| AIMS: | | |

**For off label use and polypharmacy:**

- **Off Label Use (outside FDA indication, dose range, age range):**
  is consistent with references and/or guidelines as attached (please include references)
  Is unusual due to the following reasons:
- **Polypharmacy rationale with plan to taper to monotherapy:**
  I am prescribing more than one antipsychotic for the following reasons:

  I plan to taper to monotherapy in months by discontinuing the following medications:

**TO THE BEST OF MY KNOWLEDGE ALL INFORMATION ON THIS DOCUMENT IS ACCURATE**

Prescriber Name: Prescriber Specialty:

Prescriber Signature:_______________________________________ Date: