

**ANTIPSYCHOTICS
PRIOR AUTHORIZATION FORM**

To review the prior authorization guidelines for Antipsychotics, please refer to Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Antipsychotics at <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>. Antipsychotics are subject to quantity limits – please go to: <http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/pharmacyservices/quantitylimitslist/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information

For Additional Information: Coordinator Name: _____ PA#: _____

Number of Pages in this Request: _____ Office Contact Name: _____ & Phone: (_____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____

NPI#: _____ OR MA Provider ID#: _____ State License#: _____

Prescriber Address: _____ Suite #: _____

City/State/Zip: _____ Phone: (_____) _____ Fax: (_____) _____

MEDICAL INFORMATION

Non-Preferred Agents: Abilify ODT/solution/injection Abilify Maintena Adasuve inhalation amitriptyline/perphenazine
 clozapine ODT Fanapt Invega Latuda Loxitane olanzapine tablet/ODT/injection olanzapine/fluoxetine
 risperidone ODT Saphris Seroquel XR Symbyax Versacloz Zyprexa Relprevv*

Preferred Agents: Abilify tablet chlorpromazine clozapine fluphenazine tablet/solution fluphenazine decanoate injection
 Geodon injection Haldol injection haloperidol tablet/solution haloperidol decanoate injection
 haloperidol lactate injection Invega Sustenna* loxapine Orap perphenazine quetiapine
 Risperdal Consta* risperidone tablet/solution thioridazine thiothixene trifluoperazine ziprasidone

Strength: _____ **Dosage Form:** _____ **Directions:** _____ **Quantity:** _____ **Refills:** _____

Diagnosis: _____ **Diagnosis Code:** _____ (Required)

***These injectable Antipsychotics are part of the Specialty Pharmacy Drug Program – which Specialty pharmacy will be used?**

Accredo Health Group Walgreen's Specialty Pharmacy (Invega Sustenna & Zyprexa Relprevv-only available via Walgreen's Specialty)

Request for a Non-Preferred Agent

1. Has the Recipient tried and failed the preferred medications (listed above)? Yes (submit documentation) No
2. Does the Recipient have a contraindication or intolerance to the preferred medications? Yes (submit documentation) No
3. Oral Invega Requests: Is the Recipient at risk for liver disease? Yes (submit documentation & lab values) No
4. Abilify Maintena & Zyprexa Relprevv Requests – check all that apply & submit documentation:
 Recipient is being transitioned from the oral formulation (i.e., from Abilify to Abilify Maintena; or Zyprexa to Zyprexa Relprevv)
 Recipient is at high risk of decompensation, or has a history of non-compliance with oral antipsychotics resulting in decompensation

Request for a Recipient LESS Than 18 Years of Age

1. Which of the following apply to the Recipient (check all that apply & submit documentation)?

- Severe behavioral problems related to a psychotic or neuro-developmental disorder
 Tried non-drug therapies
 Requested agent is prescribed by (or in consultation with) one of the following physician types: Child Development Pediatrician
 Child & Adolescent Psychiatrist General Psychiatrist (only if Recipient is ≥ 14 years of age) Pediatric Neurologist

2. Has the Recipient had the following baseline and/or follow-up monitoring (check all that apply & submit documentation)?

- Body Mass Index (BMI) (or weight & height) Blood Pressure Fasting Lipid Panel Fasting Glucose Level
 Presence of Extrapyramidal Symptoms using the Abnormal Involuntary Movement Scale (AIMS)

Request for a Low-Dose Oral Antipsychotic for a Recipient 18 Years of Age or OLDER

1. What is the total daily dose of the requested medication? _____ (submit documentation of full regimen)

2. Is the low dose prescribed as part of a plan to titrate up to a therapeutic dose? Yes (submit documentation of plan) No

PLEASE SEND COMPLETED FORM WITH CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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