

## 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/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request      # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

### CLINICAL INFORMATION

1. Current Medication Requested			
Preferred Agents	Non-Preferred Agents		
<input type="checkbox"/> Abilify tablet <input type="checkbox"/> haloperidol dec. inj. <input type="checkbox"/> quetiapine <input type="checkbox"/> clozapine <input type="checkbox"/> haloperidol lactate inj. <input type="checkbox"/> Risperdal Consta* <input type="checkbox"/> fluphenazine tab/sol'n <input type="checkbox"/> Invega Sustenna* <input type="checkbox"/> risperidone tab/sol'n <input type="checkbox"/> fluphenazone dec. inj. <input type="checkbox"/> Invega Trinza* <input type="checkbox"/> thioridazine <input type="checkbox"/> Geodon injection <input type="checkbox"/> loxapine <input type="checkbox"/> thiothixene <input type="checkbox"/> Haldol injection <input type="checkbox"/> Orap <input type="checkbox"/> trifluoperazine <input type="checkbox"/> haloperidol tab/sol'n <input type="checkbox"/> perphenazine <input type="checkbox"/> ziprasidone	<input type="checkbox"/> Abilify ODT/solution/injection <input type="checkbox"/> Geodon capsule <input type="checkbox"/> Risperdal tab/ODT/sol'n <input type="checkbox"/> Abilify Maintena* <input type="checkbox"/> Haldol decanoate inj. <input type="checkbox"/> risperidone ODT <input type="checkbox"/> Adasuve inhalation <input type="checkbox"/> Invega tablet <input type="checkbox"/> Saphris <input type="checkbox"/> amitriptyline/perphenazine <input type="checkbox"/> Latuda <input type="checkbox"/> Seroquel <input type="checkbox"/> aripiprazole tablet/ODT <input type="checkbox"/> molindone <input type="checkbox"/> Seroquel XR <input type="checkbox"/> Aristada ER injection** <input type="checkbox"/> olanzapine tab/ODT/inj. <input type="checkbox"/> Symbyax <input type="checkbox"/> chlorpromazine <input type="checkbox"/> olanzapine/fluoxetine <input type="checkbox"/> Versacloz <input type="checkbox"/> clozapine ODT <input type="checkbox"/> paliperidone ER tab <input type="checkbox"/> Zyprexa Relprev* <input type="checkbox"/> Clozaril <input type="checkbox"/> pimozide <input type="checkbox"/> Zyprexa tab/ODT/inj. <input type="checkbox"/> Fanapt <input type="checkbox"/> Rexulti <input type="checkbox"/> other: _____ <input type="checkbox"/> Fazaclol		
Strength:	Dosage form:	Directions:	Quantity:      Refills:
Diagnosis:		Diagnosis code (required):	
2. Injectable medications marked with a * are part of the Specialty Pharmacy Drug Program. Which Specialty Pharmacy will be used? (**Note: Aristada ER is only available from Diplomat Specialty Pharmacy.)			<input type="checkbox"/> Diplomat Specialty Pharmacy <input type="checkbox"/> Walgreens Specialty Pharmacy

#### Request for a Non-Preferred Agent:

1. Has the Recipient taken the requested non-preferred antipsychotic in the past 90 days?	<input type="checkbox"/> Yes – <u>submit documentation</u> <input type="checkbox"/> No
2. Has the Recipient tried and failed the preferred medications (listed above)?	<input type="checkbox"/> Yes – <u>submit documentation of therapeutic failure</u> <input type="checkbox"/> No
3. Does the Recipient have a contraindication or intolerance to the preferred medications?	<input type="checkbox"/> Yes – <u>submit documentation of contraindication/intolerance</u> <input type="checkbox"/> No
4. <b>For oral Invega/paliperidone ER requests</b> , is the Recipient at risk for liver disease?	<input type="checkbox"/> Yes – <u>submit documentation and lab values</u> <input type="checkbox"/> No
5. <b>For Abilify Maintena, Aristada ER, &amp; Zyprexa Relprev long-acting injection requests</b> , check all that apply and submit documentation.	
<input type="checkbox"/> Recipient is being transitioned from the oral formulation (ie, from Abilify oral to Abilify Maintena/Aristada ER, or from Zyprexa oral to Zyprexa Relprev) <input type="checkbox"/> 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. Is the requested agent prescribed by, or in consultation with, one of the following physician specialists? <input type="checkbox"/> Child Development Pediatrician <input type="checkbox"/> General Psychiatrist (only if Recipient is ≥ 14 years of age) <input type="checkbox"/> Child & Adolescent Psychiatrist <input type="checkbox"/> Pediatric Neurologist	<input type="checkbox"/> Yes <input type="checkbox"/> No (prescriber's specialty: _____)
2. Does the Recipient have severe behavioral problems related to a psychotic or neuro-developmental disorder?	<input type="checkbox"/> Yes – <u>submit medical record documentation</u> <input type="checkbox"/> No
3. Has the Recipient tried non-drug therapies?	<input type="checkbox"/> Yes – <u>submit medical record documentation</u> <input type="checkbox"/> No
4. Has the Recipient had the following baseline and/or follow-up monitoring? <u>Check all that apply.</u> <input type="checkbox"/> BMI (or weight/height) <input type="checkbox"/> Fasting glucose level <input type="checkbox"/> Presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS) <input type="checkbox"/> Blood pressure <input type="checkbox"/> Fasting lipid panel	<u>Submit documentation of all monitoring/test results</u>

#### 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? _____ mg/day	<u>Submit documentation of complete medication regimen</u>
2. Is the low dose prescribed as part of a plan to titrate up to a therapeutic dose?	<input type="checkbox"/> Yes – <u>submit documentation of titration plan</u> <input type="checkbox"/> No

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature: _____	Date: _____
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