

# ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM

(form effective 1/8/2024)



Fax to PerformRx<sup>SM</sup> at **1-888-981-5202**, or to speak to a representative, call **1-866-610-2774**.

PRIOR AUTHORIZATION REQUEST INFORMATION				
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total pages:	Office contact/phone:	LTC facility contact/phone:

PATIENT INFORMATION				
Patient name:		Patient ID#:		DOB:
Street address:			Apt #:	City/state/zip:

PRESCRIBER INFORMATION				
Prescriber name:				
Specialty:		NPI:		State license #:
Street address:			Suite #:	City/state/zip:
Phone:			Fax:	

MEDICATION REQUESTED				
<b>Preferred Agents</b>				
<input type="checkbox"/> Abilify Asimtufii	<input type="checkbox"/> fluphenazine oral concentrate	<input type="checkbox"/> haloperidol lactate	<input type="checkbox"/> lurasidone tablet	<input type="checkbox"/> quetiapine ER tablet
<input type="checkbox"/> Abilify Maintena	<input type="checkbox"/> fluphenazine tablet	<input type="checkbox"/> oral concentrate	<input type="checkbox"/> olanzapine tablet	<input type="checkbox"/> Risperdal Consta
<input type="checkbox"/> aripiprazole tablet	<input type="checkbox"/> fluphenazine decan. inj.	<input type="checkbox"/> Invega Hafyera	<input type="checkbox"/> paliperidone ER tab	<input type="checkbox"/> risperidone solution
<input type="checkbox"/> Aristada ER injection	<input type="checkbox"/> haloperidol tablet	<input type="checkbox"/> Invega Sustenna	<input type="checkbox"/> perphenazine tablet	<input type="checkbox"/> risperidone tablet
<input type="checkbox"/> Aristada Initio injection	<input type="checkbox"/> haloperidol decanoate inj.	<input type="checkbox"/> Invega Trinza	<input type="checkbox"/> Perseris ER injection	<input type="checkbox"/> trifluoperazine tablet
<input type="checkbox"/> clozapine tablet	<input type="checkbox"/> haloperidol lactate inj.	<input type="checkbox"/> loxapine capsule	<input type="checkbox"/> quetiapine tablet	<input type="checkbox"/> ziprasidone capsule
<input type="checkbox"/> ziprasidone capsule				<input type="checkbox"/> Zyprexa Relprev
<b>Non-Preferred Agents</b>				
<input type="checkbox"/> Abilify Mycite	<input type="checkbox"/> chlorpromazine inj.	<input type="checkbox"/> Geodon capsule	<input type="checkbox"/> Nuplazid tablet	<input type="checkbox"/> Secuado patch
<input type="checkbox"/> Abilify tablet	<input type="checkbox"/> chlorpromazine solution	<input type="checkbox"/> Geodon injection	<input type="checkbox"/> olanzapine inj/ODT	<input type="checkbox"/> Seroquel tablet
<input type="checkbox"/> Adasuve inhalation	<input type="checkbox"/> chlorpromazine tablet	<input type="checkbox"/> Haldol decanoate inj.	<input type="checkbox"/> olanzapine/fluoxetine cap	<input type="checkbox"/> Seroquel XR tablet
<input type="checkbox"/> amitriptyline/perphenazine	<input type="checkbox"/> clozapine ODT	<input type="checkbox"/> Invega ER tablet	<input type="checkbox"/> pimozide tablet	<input type="checkbox"/> Symbyax capsule
<input type="checkbox"/> aripiprazole ODT	<input type="checkbox"/> Clozaril tablet	<input type="checkbox"/> Latuda tablet	<input type="checkbox"/> Rexulti tablet	<input type="checkbox"/> thioridazine tablet
<input type="checkbox"/> aripiprazole solution	<input type="checkbox"/> Fanapt tablet	<input type="checkbox"/> Lybalvi	<input type="checkbox"/> Risperdal solution/tablet	<input type="checkbox"/> thiothixene capsule
<input type="checkbox"/> asenapine SL	<input type="checkbox"/> fluphenazine elixir	<input type="checkbox"/> molindone tablet	<input type="checkbox"/> risperidone ODT	<input type="checkbox"/> Uzedly ER
<input type="checkbox"/> Caplyta capsules	<input type="checkbox"/> fluphenazine HCl injection	<input type="checkbox"/> Nuplazid capsule	<input type="checkbox"/> Saphris SL tablet	<input type="checkbox"/> Versacloz suspension
				<input type="checkbox"/> Vraylar capsule
				<input type="checkbox"/> Ziprasidone inj.
				<input type="checkbox"/> Zyprexa tablet/injection
				<input type="checkbox"/> Zyprexa Zydys
				<input type="checkbox"/> other:
Strength:	Dosage form:	Directions:	Quantity:	Refills:
Diagnosis:			Diagnosis code (required):	

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):	
Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

REQUEST FOR A NON-PREFERRED AGENT	
1. Has the patient taken the requested non-preferred antipsychotic in the past 90 days?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No
2. Has the patient tried and failed the preferred medications (listed above)?	<input type="checkbox"/> Yes – List medications tried: <input type="checkbox"/> No
3. Does the patient have a contraindication or intolerance to the preferred medications?	<input type="checkbox"/> Yes – <i>Submit documentation of contraindication/intolerance.</i> <input type="checkbox"/> No

REQUEST FOR A PATIENT LESS THAN 18 YEARS OF AGE	
4. For renewal requests, has the patient had improvement in target symptoms with use of this medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is this request for a dose increase of a previously approved medication or request over the plan limits?	<input type="checkbox"/> Yes – <i>Submit recent chart documentation and/or treatment guidelines supporting the requested dose.</i> <input type="checkbox"/> No
6. For renewal requests, is there a plan for taper/discontinuation or rationale for continued use of requested drug ?	<input type="checkbox"/> Yes <i>Submit supporting documentation.</i> <input type="checkbox"/> No
7. Is the requested agent prescribed by, or in consultation with, one of the following physician specialists?	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation of consultation, if applicable.</i>
<input type="checkbox"/> child development pediatrician <input type="checkbox"/> child & adolescent psychiatrist <input type="checkbox"/> general psychiatrist (only if patient is ≥ 14 years of age) <input type="checkbox"/> pediatric neurologist	
8. Does the patient have severe symptoms related to a psychotic or neuro-developmental disorder?	<input type="checkbox"/> Yes – <i>Submit medical record documentation.</i> <input type="checkbox"/> No
9. Has chart documented evidence of comprehensive evaluation and plan of care that includes non-drug therapies?	<input type="checkbox"/> Yes – <i>Submit medical record documentation.</i> <input type="checkbox"/> No
10. Has the patient had the following baseline and/or follow-up monitoring? <u>Check all that apply.</u>	<input type="checkbox"/> BMI and/or weight (for follow-up monitoring this must be done quarterly) <input type="checkbox"/> blood pressure
<input type="checkbox"/> fasting blood glucose or hemoglobin a1c <input type="checkbox"/> fasting lipid panel <input type="checkbox"/> presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)	
<i>Submit documentation of all monitoring/test results and dates.</i>	

REQUEST FOR THERAPEUTIC DUPLICATION OF AN ATYPICAL OR TYPICAL ANTIPSYCHOTIC	
11. Does the patient have a medical reason for concomitant use of the requested medications?	<input type="checkbox"/> Yes – <i>Submit documentation of treatment guidelines supporting concomitant use.</i> <input type="checkbox"/> No
12. Is this request for a drug that is being titrated to, or tapered from, a drug in the same class?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION	
Prescriber signature:	Date:

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