

ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM

(form effective 1/5/21)



Fax to PerformRxSM 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					
Preferred Agents					
<input type="checkbox"/> Abilify Maintena	<input type="checkbox"/> fluphenazine elixir	<input type="checkbox"/> haloperidol tablet	<input type="checkbox"/> Invega Sustenna	<input type="checkbox"/> Perseris ER injection	<input type="checkbox"/> risperidone tablet
<input type="checkbox"/> aripiprazole tablet	<input type="checkbox"/> fluphenazine oral concentrate	<input type="checkbox"/> haloperidol decanoate inj	<input type="checkbox"/> Invega Trinza	<input type="checkbox"/> quetiapine tablet	<input type="checkbox"/> trifluoperazine tablet
<input type="checkbox"/> Aristada ER injection	<input type="checkbox"/> fluphenazine tablet	<input type="checkbox"/> haloperidol lactate inj.	<input type="checkbox"/> loxapine capsule	<input type="checkbox"/> quetiapine ER tablet	<input type="checkbox"/> ziprasidone capsule
<input type="checkbox"/> Aristada Initio injection	<input type="checkbox"/> fluphenazine decan. inj.	<input type="checkbox"/> haloperidol lactate oral concentrate	<input type="checkbox"/> olanzapine tablet	<input type="checkbox"/> Risperdal Consta	<input type="checkbox"/> Zyprexa Relprevv
<input type="checkbox"/> clozapine tablet	<input type="checkbox"/> Haldol injection		<input type="checkbox"/> perphenazine tablet	<input type="checkbox"/> risperidone solution	
Non-Preferred Agents					
<input type="checkbox"/> Abilify Mycite	<input type="checkbox"/> chlorpromazine tablet	<input type="checkbox"/> Geodon injection	<input type="checkbox"/> olanzapine inj/ODT	<input type="checkbox"/> Saphris SL tablet	<input type="checkbox"/> Versacloz suspension
<input type="checkbox"/> Abilify tablet	<input type="checkbox"/> clozapine ODT	<input type="checkbox"/> Haldol decanoate inj.	<input type="checkbox"/> olanzapine/fluoxetine cap	<input type="checkbox"/> Secuado patch	<input type="checkbox"/> Vraylar capsule
<input type="checkbox"/> Adasuve inhalation	<input type="checkbox"/> Clozaril tablet	<input type="checkbox"/> Invega ER tablet	<input type="checkbox"/> paliperidone ER tab	<input type="checkbox"/> Seroquel tablet	<input type="checkbox"/> Zyprexa tablet/injection
<input type="checkbox"/> amitripyline/perphenazine	<input type="checkbox"/> Fanapt tablet	<input type="checkbox"/> Latuda tablet	<input type="checkbox"/> pimozide tablet	<input type="checkbox"/> Seroquel XR tablet	<input type="checkbox"/> Zyprexa Zydys
<input type="checkbox"/> aripiprazole ODT	<input type="checkbox"/> Fazaclo dispersible tablet	<input type="checkbox"/> molindone tablet	<input type="checkbox"/> Rexulti tablet	<input type="checkbox"/> Symbyax capsule	<input type="checkbox"/> other:
<input type="checkbox"/> aripiprazole solution	<input type="checkbox"/> fluphenazine HCl injection	<input type="checkbox"/> Nuplazid capsule	<input type="checkbox"/> Risperdal solution/tablet	<input type="checkbox"/> thioridazine tablet	
<input type="checkbox"/> Caplyta capsules	<input type="checkbox"/> Geodon capsule	<input type="checkbox"/> Nuplazid tablet	<input type="checkbox"/> risperidone ODT	<input type="checkbox"/> thiothixene capsule	
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	4. For oral Invega/paliperidone ER requests, does the patient have active liver disease with elevated LFTs or is the patient at risk for active liver disease? <input type="checkbox"/> Yes – <i>Submit documentation and lab values.</i> <input type="checkbox"/> No

REQUEST FOR A PATIENT LESS THAN 18 YEARS OF AGE	
5. Is this request for a dose increase of a previously approved medication? <input type="checkbox"/> Yes – <i>Submit recent chart documentation supporting the increased dose.</i> <input type="checkbox"/> No	
6. 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	
7. Does the patient have severe behavioral problems related to a psychotic or neuro-developmental disorder? <input type="checkbox"/> Yes – <i>Submit medical record documentation.</i> <input type="checkbox"/> No	
8. Has the patient tried non-drug therapies? <input type="checkbox"/> Yes – <i>Submit medical record documentation.</i> <input type="checkbox"/> No	
9. Has the patient had the following baseline and/or follow-up monitoring? <i>Check all that apply.</i> <input type="checkbox"/> BMI (or weight/height) <input type="checkbox"/> blood pressure <input type="checkbox"/> fasting glucose level <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.</i>	

REQUEST FOR A LOW-DOSE ORAL ANTIPSYCHOTIC FOR A PATIENT 18 YEARS OF AGE OR OLDER	
10. What is the TOTAL daily dose of the requested medication? _____mg/day <i>Submit documentation of complete medication regimen.</i>	
11. Is the low dose prescribed as part of a plan to titrate up to a therapeutic dose? <input type="checkbox"/> Yes – <i>Submit documentation of titration plan.</i> <input type="checkbox"/> No	

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

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

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