pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM *(form effective 1/28/19)*

Antipsychotics and **Quantity Limits/Daily Dose Limits** guidelines are available at http://www.dhs.pa.us/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Office contact/phone:		Specialty:	
LTC facility contact/phone:		NPI:	State license #:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

Medication Requested

Preferred Agents			Non-Preferred Agents		
☐aripiprazole tablet	☐Haldol injection	☐Perseris ER injection**	☐Abilify Maintena*	☐Haldol decanoate inj.	☐risperidone ODT
☐Aristada ER injection**	☐haloperidol tablet	☐quetiapine tablet	☐Abilify tablet	☐Invega ER tablet	☐Saphris SL tablet
☐Aristada Initio injection**	☐haloperidol decanoate inj	☐quetiapine ER tablet	☐Adasuve inhalation	☐Latuda tablet	☐Seroquel tablet
☐clozapine tablet	☐haloperidol lactate inj.	☐Risperdal Consta*	☐amitriptyline/perphenazine	☐molindone tablet	☐Seroquel XR tablet
☐fluphenazine elixir	☐haloperidol lactate oral	☐risperidone solution	☐aripiprazole ODT	☐Nuplazid capsule	☐Symbyax capsule
☐fluphenazine injection	concentrate	☐risperidone tablet	☐aripiprazole solution	☐Nuplazid tablet	☐Versacloz suspension
☐fluphenazine oral	☐Invega Sustenna*	☐thioridazine tablet	☐chlorpromazine tablet	☐olanzapine inj/ODT/tab	☐Vraylar capsule
concentrate	☐Invega Trinza**	☐thiothixene capsule	☐clozapine ODT	☐olanzapine/fluoxetine cap	☐Zyprexa tablet/injection
☐fluphenazine tablet	☐loxapine capsule	☐trifluoperazine tablet	☐Clozaril tablet	☐paliperidone ER tab	☐Zyprexa Relprevv*
☐fluphenazine decan. inj.	☐Orap tablet	☐ziprasidone capsule	☐Fanapt tablet	☐pimozide tablet	☐Zyprexa Zydis
☐Geodon injection	☐perphenazine tablet		☐Fazaclo dispersible tablet	☐Rexulti tablet	☐other: _____
			☐Geodon capsule	☐Risperdal solution/tablet	

Strength:	Dosage form:	Directions:	Quantity:	Refills:

Diagnosis:	Diagnosis code (*required*):

Injectable medications marked with a * are part of the Specialty Pharmacy Drug Program. Which specialty pharmacy will be used? (**Note: Aristada ER/Aristada Initio, Invega Trinza, and Perseris ER are only available from Diplomat Specialty Pharmacy.)	☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy

REQUEST FOR A NON-PREFERRED AGENT

1. Has the beneficiary taken the requested non-preferred antipsychotic in the past 90 days?	☐Yes – *Submit documentation.* ☐No
2. Has the beneficiary tried and failed the preferred medications (listed above)?	☐Yes – *Submit documentation of therapeutic failure.* ☐No
3. Does the beneficiary have a contraindication or intolerance to the preferred medications?	☐Yes – *Submit documentation of contraindication/intolerance.* ☐No
4. ***For oral Invega/paliperidone ER requests***, is the beneficiary at risk for liver disease?	☐Yes – *Submit documentation and lab values.* ☐No

5. ***For Abilify Maintena ER & Zyprexa Relprevv long-acting injection requests***, check any of the following that apply and submit documentation.
☐Beneficiary is being transitioned from the oral formulation (i.e., from Abilify oral to Abilify Maintena or from Zyprexa oral to Zyprexa Relprevv)
☐Beneficiary is at high risk of decompensation or has a history of non-compliance with oral antipsychotics resulting in decompensation

REQUEST FOR A BENEFICIARY LESS THAN 18 YEARS OF AGE

6. Is this request for a dose increase of a previously approved medication? ☐Yes – *Submit recent chart documentation supporting the increased dose.* ☐No

7. Is the requested agent prescribed by, or in consultation with, one of the following physician specialists? ☐child development pediatrician ☐general psychiatrist (only if beneficiary is ≥ 14 years of age) ☐child & adolescent psychiatrist ☐pediatric neurologist	☐Yes ☐No *Submit documentation of consultation, if applicable.*
8. Does the beneficiary have severe behavioral problems related to a psychotic or neuro-developmental disorder?	☐Yes – *Submit medical record documentation.* ☐No
9. Has the beneficiary tried non-drug therapies?	☐Yes – *Submit medical record documentation.* ☐No
10. Has the beneficiary had the following baseline and/or follow-up monitoring? Check all that apply. ☐BMI (or weight/height) ☐fasting glucose level ☐presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS) ☐blood pressure ☐fasting lipid panel	*Submit documentation of all monitoring/test results.*

REQUEST FOR A LOW-DOSE ORAL ANTIPSYCHOTIC FOR A BENEFICIARY 18 YEARS OF AGE OR OLDER

11. What is the TOTAL daily dose of the requested medication? _____mg/day	*Submit documentation of complete medication regimen.*
12. Is the low dose prescribed as part of a plan to titrate up to a therapeutic dose?	☐Yes – *Submit documentation of titration plan.* ☐No

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

Prescriber Signature:	**Date**: