pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND
SUBSTANCE ABUSE SERVICES

Special Pharmaceutical Benefits Program - Mental Health

INSTRUCTIONS FOR COMPLETING THE SPECIAL PHARMACEUTICAL BENEFITS PROGRAM APPLICATION FOR ATYPICAL ANTI-PSYCHOTIC MEDICATIONS

The Special Pharmaceutical Benefits Program for Mental Health (SPBP-MH) is administered by the Pennsylvania Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS) and provides payment for specific atypical antipsychotic medications for eligible participants. The SPBP-MH formulary is Abilify, Clozaril, Clozapine, Geodon, Invega, Risperdal, Risperidone, Seroquel, and Zyprexa.

To be considered for benefits through the SPBP-MH or to recertify your eligibility for SPBP-MH, you must complete an application and submit it with copies of required documentation. Please print the information on the application legibly.

Eligibility for the SPBP-MH is determined by the following criteria:

Income Limits:	Individuals - $35,000 gross income per year
	Families - $35,000 gross income per year, plus an allowance of $2,893 for each additional family member. (Example: family of two $37,893 combined gross; family of three $40,786 combined gross)
Residence:	Must be a Pennsylvania resident living in Pennsylvania and not institutionalized.
Medical Need:	Must have a medical need with a ICD-10-CM diagnosis of schizophrenia.

You and your physician must sign and date the application (Section 7 and 8). The application must be received no more than 30 days after you and your physician sign and date the application.

THE PROCESSING OF YOUR SPBP-MH APPLICATION WILL BE DELAYED DUE TO INCOMPLETE OR MISSING INFORMATION.

You must submit copies of the following documentation with your SPBP-MH application:

- Proof of Residence (PA Driver's License, PA State issued identification card, or utility bill)
- Income (Include proof for you and your family members)
- Social Security Card as issued by the Social Security Administration
- Your prescription for a medication prescribed for schizophrenia (An original prescription is required and must include the date of issue, name of patient, name of the medication being prescribed, the diagnosis code, and the written diagnosis description. The prescription must include the prescribing physician's name, address, and license number. The physician identified in Section 8 of the application must be the physician who completes the prescription.)

Do not send cash register receipts, pharmacy printouts, or a hand-printed list of drugs.

PLEASE NOTE: Medical Assistance (MA) program recipients, including individuals receiving services through HealthChoices, are not eligible for a SPBP-MH card, and should not apply. The MA program covers medication for schizophrenia.

If you are eligible for Medicare Part A or Part B, you should enroll in Medicare Part D and apply to the SPBP-MH to cover your outstanding expenses such as premiums, co-payments, and deductibles for SPBP-MH covered drugs.

If you have other health insurance that pays for drugs, you can still apply for SPBP-MH. If you are approved for SPBP-MH, SPBP-MH is the payer of last resort (other insurance carriers will be billed first).

You must promptly advise the SPBP-MH program of any changes in name, address, diagnosis, insurance coverage, and/or income.

Return the completed application and copies of the required documentation to:

Department of Human Services - OMHSAS
Business Partner Support Unit - SPBP-MH Program
Commonwealth Tower 12th Floor
P.O. Box 2675
Harrisburg, PA 17105-2675

Telephone: 1-800-433-4459

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Check the box which applies: If you are NOT enrolled and receiving benefits at this time, please check the box for New Enrollment. If you are currently enrolled and receiving benefits, please check the box for Recertification. For both New Enrollment and Recertification, please be sure to provide supporting documentation.

Section 1 Enter your full name, date of birth, and sex.

Enter your principal place of residence and provide proof with your application. The address on your application must match supporting proof of your residence. Some examples you may use for proof of residence are: PA driver's license, PA state issued ID card, phone/utility bill.

Enter your Social Security number and provide a copy of your Social Security card. If you are recertifying your enrollment, you are not required to provide a copy of your Social Security card.

Enter a home phone number or a cell phone number, or both.

Section 2 Enter your ethnicity and race. This information is optional.

Section 3 Complete this section if there is an individual who has Power of Attorney and is permitted to act on your behalf and provide supporting documentation, such as a copy of the Power of Attorney (POA). Enter the power of attorney's name, phone number, and address.

Section 4 Provide information regarding your family composition. A family is considered a spouse, children under 18, and parents of children under 18 who live together. (NOTE: single/unmarried applicants over 18 with no dependents do not list household members.)

Section 5 Provide income information for yourself and each member of your family identified in Section 4. You must complete this section.

Financial eligibility will be determined based upon the gross income of the applicant/family. Gross income is income before deduction of taxes. For individuals who are self-employed, report net profit or loss.

Proof of income must be provided. For wage earners, proof should be provided by copies of pay stubs for the previous 30 days. If a pay stub is not available, a letter from the employer indicating gross pay for the last 30 calendar days should be sent.

Individuals who are self-employed should provide business records for the three months prior to application indicating the gross income and net profit or loss and/or federal tax returns for the most recent year.

Proof of other income including social security award letter, pension checks, or a benefit award letter should be provided as proof of other types of income.

If you have zero income, you must provide documentation in the form of a letter explaining how your daily needs are being met. You must also respond to the two questions at the bottom of page 4 if your gross income is zero.

Section 6 Indicate whether you have Medicare Part A (Hospital) and/or Medicare Part B (Medical), or Medicare Part D (Rx) coverage insurance. Indicate if you have other health insurance. Indicate the name and address of the insurance company.

Indicate if the insurance premiums are paid by you, your employer, union, or other (if other - explain). If you pay your own premiums, indicate the cost per year. Indicate if your health insurance is a major medical plan or a supplement to Medicare. Indicate the amount of your annual deductible. Indicate any copay for brand name drugs and generic drugs. (NOTE: If the policy holder is other than you, indicate information in appropriate blocks.)

Section 7 Read, sign, and date your application.

Section 8 Your physician must sign and date this section and include his/her license number. The physician who signs the application must be the same physician who writes the prescription.

Check the boxes below to be sure you have enclosed copies of:

- ☐ Proof of residence
- ☐ Social Security card (for new enrollments only)
- ☐ Proof of income
- ☐ An original prescription (The prescription must include the date of issue, name of patient, name of medication, diagnosis code and description, and prescribing physician, address and license number.)

THE PROCESSING OF YOUR SPBP-MH APPLICATION WILL BE DELAYED DUE TO INCOMPLETE OR MISSING INFORMATION.

PLEASE ALLOW UP TO 30 DAYS FOR PROCESSING - YOU WILL BE NOTIFIED IN WRITING OF THE APPLICATION STATUS. STATUS UPDATES ARE NOT PROVIDED VIA PHONE.

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☐ CHECK THIS BOX IF NEW ENROLLMENT ☐ CHECK THIS BOX IF RECERTIFICATION

1. Personal Information - Refer to Section 1 of the instructions.

You are required to provide your legal name exactly as it appears on your Social Security card.

LEGAL NAME (LAST)	(FIRST)	(M.I.)	DATE OF BIRTH	SEX
				☐ MALE ☐ FEMALE

Provide proof of your principal place of residence. The address on this application must match supporting documentation. Examples you may use as proof of residency are: PA driver's license, PA state issued ID card, or utility bill.

HOME ADDRESS	CITY	STATE	ZIP	COUNTY

APPLICANT'S SOCIAL SECURITY NUMBER	HOME PHONE NUMBER	CELL PHONE NUMBER
	( )	( )

A copy of your social security card is required for new enrollments.

2. Check one box for your ethnicity and one box for your race - Refer to Section 2 of the instructions.

ETHNICITY (OPTIONAL)
☐ Hispanic/Latino (A)
☐ Non-Hispanic

RACE (OPTIONAL)
☐ Black or African-American
☐ American Indian or Alaska Native
☐ White
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Other:

3. Authorized Representative - Refer to Section 3 of the instructions.

☐ Check box if there is an individual who has Power of Attorney and is permitted to act on your behalf. **Please submit supporting documentation.**

POWER OF ATTORNEY'S NAME (PRINT)	PHONE NUMBER
	( )

POWER OF ATTORNEY'S ADDRESS	CITY	STATE	ZIP

4. Family Composition - Refer to Section 4 of the instructions.

If needed, attach a separate sheet listing additional family members.

NAME (LAST, FIRST, MIDDLE INITIAL)	DATE OF BIRTH	SEX		SOCIAL SECURITY #	RELATIONSHIP TO YOU
		M	F		

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5. Provide income information below for you and each member of your family - Refer to Section 5 of the instructions.
If needed, attach a separate sheet listing additional family members.

TYPE OF INCOME	INCOME RECEIVED PER MONTH		
	APPLICANT	SPOUSE OR OTHER FAMILY MEMBER LISTED IN SECTION 4	DEPENDENT
SALARY, WAGES, BONUSES, COMMISSIONS	$	$	$
UNEMPLOYMENT BENEFITS	$	$	$
VETERANS' BENEFITS	$	$	$
SOCIAL SECURITY RETIREMENT/SURVIVOR'S BENEFITS	$	$	$
OTHER PENSIONS OR RETIREMENT	$	$	$
SOCIAL SECURITY DISABILITY	$	$	$
UNION BENEFITS	$	$	$
WORKERS' COMPENSATION OR SICK BENEFITS	$	$	$
OTHER DISABILITY INCOME	$	$	$
ALIMONY OR CHILD SUPPORT	$	$	$
DIVIDENDS, INTEREST, ROYALTIES	$	$	$
RENTAL INCOME (GROSS MINUS EXPENSES)	$	$	$
PUBLIC ASSISTANCE (EXCLUDING FOOD STAMPS AND LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM - LIHEAP)	$	$	$
SUPPLEMENTAL SECURITY INCOME (SSI)	$	$	$
SELF EMPLOYMENT INCOME	$	$	$
OTHER INCOME	$	$	$
TOTAL	$	$	$

If your gross income is zero, have you applied for Medical Assistance? ☐ Yes ☐ No If yes, date: _____

If your gross income is zero, have you applied for Social Security benefits? ☐ Yes ☐ No If yes, date: _____

If your gross income is zero, attach a letter telling us how you support yourself.

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6. Health Insurance Information - Refer to Section 6 of the instructions.

Do you have Medicare Part A (Hospital Insurance)? ☐ Yes ☐ No

Do you have Medicare Part B (Medical Insurance)? ☐ Yes ☐ No

Do you have Medicare Part D? ☐ Yes ☐ No

Do you have other health insurance coverage? ☐ Yes ☐ No
If yes, please identify.

NAME OF INSURANCE COMPANY	POLICY HOLDER NAME (IF NOT APPLICANT)
ADDRESS	POLICY HOLDER ADDRESS (IF NOT APPLICANT
GROUP NUMBER/POLICY NUMBER	POLICY HOLDER SSN (IF NOT APPLICANT)

Is this health insurance: ☐ Major Medical Plan ☐ Supplement to Medicare ☐ Other What is your annual deductible? $

Indicate if the insurance premiums are paid by: ☐ Employer ☐ Union ☐ Self ☐ Other (If other, explain.)

If you pay your own premiums, indicate the total annual amount. $

If your plan covers prescriptions except co-pay, what is the co-pay amount? $

Do you pay a different co-pay for brand name and generic drugs? Brand name: $ Generic: $

7. Certification Statement (MUST be signed and dated by you or your authorized representative) - Refer to Section 7 of the Instructions.

I hereby certify that all of the above information is true and correct and that I am a Pennsylvania resident currently being treated for schizophrenia.

- I understand this information is being given in connection with an application for the Commonwealth of Pennsylvania SPBP-MH.
- I understand Program Officials may verify the information on this form.
- I understand that any false statements may subject me to be prosecuted under state and federal laws including Title 18 Pa. C.S. § 4904.

NOTE: This application must be received no more than 30 days after you have signed and dated it.

SIGNATURE OF APPLICANT (OR LEGAL GUARDIAN, IF PATIENT IS A MINOR) OR POWER OF ATTORNEY

DATE

8. Attestation Statement (MUST be signed and dated by a licensed physician) - Refer to Section 8 of the Instructions.

I understand that by signing this Attestation Statement and by entering the ICD-10-CM diagnosis of schizophrenia on the attached prescription I am certifying that the information is true and accurate and based upon my personal knowledge. I also understand that payment for specific atypical antipsychotic medications will be sought from state funds available under the SPBP-MH. I further understand that misrepresentation, concealment, or falsification of information concerning the diagnosis of this applicant may subject me to civil or criminal penalties under state and federal laws.

NOTE: This application must be received no more than 30 days after you have signed and dated it.

PHYSICIAN'S SIGNATURE

LICENSE NUMBER

DATE

You must advise the SPBP-MH staff of any changes in address and/or income immediately or risk termination of benefits.

Return the completed application and copies of the required documentation to:

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