

ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM (form effective 1/1/20)

Prior authorization guidelines for **Antipsychotics** and **Quantity Limits/Daily Dose Limits** guidelines are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Phone of office contact:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Dosage form (tablet, solution, etc.):	Strength:	
Directions:		Quantity:	Refills:
Diagnosis (submit documentation):		Diagnosis code (required):	

REQUEST FOR A NON-PREFERRED AGENT

Has the beneficiary taken the requested non-preferred antipsychotic in the past 90 days?	<input type="checkbox"/> Yes – Submit documentation. <input type="checkbox"/> No
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred medications in this class? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.	<input type="checkbox"/> Yes – Submit documentation of therapeutic failure. <input type="checkbox"/> No

REQUEST FOR A BENEFICIARY LESS THAN 18 YEARS OF AGE

Is this request for a dose increase of a previously approved medication?	<input type="checkbox"/> Yes – Submit recent chart documentation supporting the increased dose. <input type="checkbox"/> No
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 beneficiary is ≥ 14 years of age) <input type="checkbox"/> child & adolescent psychiatrist <input type="checkbox"/> pediatric neurologist	<input type="checkbox"/> Yes Submit documentation of consultation, if applicable. <input type="checkbox"/> No
Does the beneficiary have severe behavioral problems related to a psychotic or neuro-developmental disorder?	<input type="checkbox"/> Yes Submit medical record documentation. <input type="checkbox"/> No
Has the beneficiary tried non-drug therapies?	<input type="checkbox"/> Yes Submit documentation of therapies tried. <input type="checkbox"/> No
Did the beneficiary have the following baseline and/or follow-up monitoring? Check all that apply and <u>submit documentation</u> for each item. <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)	

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

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

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

Prescriber Signature:	Date:
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