Fax completed prior authorization request form to 877-309-8077 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

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

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

☐New request ☐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?	☐Yes – *Submit documentation.* ☐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.*	☐Yes – *Submit documentation of therapeutic failure.* ☐No
REQUEST FOR A BENEFICIARY LESS THAN 18 YEARS OF AGE	
Is this request for a dose increase of a previously approved medication?	☐Yes – *Submit recent chart documentation supporting the increased dose.* ☐No
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.*
Does the beneficiary have severe behavioral problems related to a psychotic or neuro-developmental disorder?	☐Yes ☐No *Submit medical record documentation.*
Has the beneficiary tried non-drug therapies?	☐Yes ☐No *Submit documentation of therapies tried.*

Did the beneficiary have the following baseline and/or follow-up monitoring? *Check all that apply and submit documentation for each item.*

- ☐BMI (or weight/height)
- ☐blood pressure
- ☐fasting glucose level
- ☐fasting lipid panel
- ☐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?	☐Yes – *Submit documentation of titration plan.* ☐No

FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO AETNA PHARMACY 1-877-309-8077

Prescriber Signature:	**Date**: