Prior Authorization Request Form for Antipsychotics

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Member has taken the requested non-preferred antipsychotic in the past 90 days? **(does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)**	☐ Yes ☐ No	*Submit documentation.*
Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Antipsychotics? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

Therapeutic Duplication:
If concurrently prescribed a therapeutic duplicate (i.e. another Antipsychotics or dose different from the agent being requested):

- ☐ For an atypical antipsychotic, member is being titrated to or tapered from another atypical antipsychotic
- ☐ For a typical antipsychotic, member is being titrated to or tapered from another typical antipsychotic
- ☐ Member has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines

Quantity Limit:

- ☐ If requesting for daily quantity exceeding daily limit (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), please provide supporting information:_____

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

REQUEST FOR INVEGA:

- ☐ Member has a history of therapeutic failure, contraindication or intolerance of the preferred Antipsychotics:_____
- ☐ Member has active liver disease with elevated LFTs or is at risk for active liver disease

REQUEST FOR A MEMBER LESS THAN 18 YEARS OF AGE:

- ☐ Request for a dose increase of previously approved medication
- ☐ Prescribed by or in consultation with a child development pediatrician, general psychiatrist (only if member is older than 14 years old), child & adolescent psychiatrist or pediatric neurologist:_____

- ☐ Member has severe behavioral problems related to psychotic or neuro-developmental disorder such as, but not limited to: Autism spectrum disorder, Intellectual disability, Conduct disorder, Bipolar disease, Tic disorder (including Tourette's syndrome), Transient encephalopathy, Schizophrenia:_____
- ☐ Member has had a comprehensive evaluation as evident by chart notes (chart notes need to be provided)
- ☐ Member has tried non-drug therapy (evidence-based behavioral, cognitive, and family based therapies) as evident by chart notes:_____
- ☐ Member has the following baseline and/or follow-up monitoring. Check all that apply and submit documentation for each.
  - ☐ BMI (or weight and height):_____
  - ☐ Blood pressure:_____
  - ☐ Fasting glucose level:_____
  - ☐ Fasting lipid panel:_____
  - ☐ Presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS):_____

RENEWAL REQUESTS FOR A MEMBER LESS THAN 18 YEARS OF AGE:

- ☐ Member has the following baseline and/or follow-up monitoring. Check all that apply and submit documentation for each.
  - ☐ Improvement in target symptoms evident by:_____
  - ☐ BMI or weight monitored quarterly:_____
  - ☐ Blood pressure:_____
  - ☐ Fasting glucose level:_____
  - ☐ Fasting lipid panel:_____
  - ☐ Presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS) after the first 3 months then annually:_____
  - ☐ Plan for taper/discontinuation of the Antipsychotic or rational for continued use:_____

RENEWAL REQUESTS FOR A MEMBER 18 YEARS OF AGE OR OLDER:

- ☐ Documentation of tolerability and experienced a positive clinical response to requested medication evident by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)