

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.  
**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**  
**Allow at least 24 hours for review.**

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:		Specialty:
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:		Allergies:	City:	State:	ZIP Code:
Medication Information					
Medication:				Strength:	
Directions for use:				Quantity:	
Medication Administered: <input type="checkbox"/> Self-Administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Other: _____					
Clinical Information					
What is the patient's diagnosis for the medication being requested? _____ _____					
ICD-10 Code(s): _____					
Are there any supporting laboratory or test results related to the patient's diagnosis? <i>(Please specify or provide documentation)</i>					
Previous Medication Trials / Contraindications					
<b><u>Please refer to the patient's PDL at <a href="http://www.uhcprovider.com">www.uhcprovider.com</a> for a list of preferred alternatives</u></b>					
What medication(s) does the patient have a history of <b>failure</b> to? <i>(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)</i>					
What medication(s) does the patient have a <b>contraindication or intolerance</b> to? <i>(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)</i>					
Additional information that may be important for this review					

<b>Member First name:</b>	<b>Member Last name:</b>	<b>Member DOB:</b>
<b>Clinical and Drug Specific Information</b>		
<b>ALL REQUESTS</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of therapeutic failure, contraindication, or intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred antipsychotics?</b> <i>(If yes, complete "Previous Medication Trials/Contraindications" section on first page)</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a current history (within the past 90 days) of being prescribed the same requested medication?</b>	
<b>INVEGA (PALIPERIDONE ER)</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have active liver disease with elevated liver function tests (LFTs) or is at risk for active liver disease?</b>	
<b>LESS THAN 18 YEARS OF AGE</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses? <i>(If yes, check which applies)</i></b> <input type="checkbox"/> Autism spectrum disorder <input type="checkbox"/> Bipolar disease <input type="checkbox"/> Conduct disorder <input type="checkbox"/> Intellectual disability <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Tic disorder, including Tourette's syndrome <input type="checkbox"/> Transient encephalopathy	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the requested medication being prescribed by or in consultation with one of the following?</b> <i>(If yes, check which applies)</i> <input type="checkbox"/> Child and adolescent psychiatrist <input type="checkbox"/> General psychiatrist <input type="checkbox"/> Child development pediatrician <input type="checkbox"/> Pediatric neurologist	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies such as, but not limited to, evidence-based behavioral, cognitive, and family based therapies?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)?</b>	
<b>CONTINUATION OF THERAPY – LESS THAN 18 YEARS OF AGE</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have documented improvement in target symptoms?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have documented monitoring of weight or body mass index (BMI) quarterly?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have documented monitoring of blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS) after the first 3 months of therapy and then annually?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there a documented plan for taper/discontinuation of the antipsychotic or rationale for continued use?</b>	
<b>THERAPEUTIC DUPLICATION</b>		
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>For an <u>atypical</u> antipsychotic, is the patient being titrated to, or tapered from, another atypical antipsychotic?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>For a <u>typical</u> antipsychotic, is the patient being titrated to, or tapered from, another typical antipsychotic?</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the prescriber have a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?</b>	

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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