



## 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 DOCUMENTATION (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? <b>(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)</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit documentation.</i>	
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 <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class.		<input type="checkbox"/> Yes <i>Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.</i> <input type="checkbox"/> No	
<b>Therapeutic Duplication:</b> If concurrently prescribed a therapeutic duplicate (i.e. another Antipsychotics or dose different from the agent being requested): <ul style="list-style-type: none"><li><input type="checkbox"/> For an atypical antipsychotic, member is being titrated to or tapered from another atypical antipsychotic</li><li><input type="checkbox"/> For a typical antipsychotic, member is being titrated to or tapered from another typical antipsychotic</li><li><input type="checkbox"/> Member has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines</li></ul>			
<b>Quantity Limit:</b> <input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to <a href="https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx">https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx</a> ), please provide supporting information: _____			
<b>SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.</b>			
<b>REQUEST FOR INVEGA:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Member has a history of therapeutic failure, contraindication or intolerance of the preferred Antipsychotics: _____</li><li><input type="checkbox"/> Member has active liver disease with elevated LFTs or is at risk for active liver disease</li></ul>			
<b>REQUEST FOR A MEMBER LESS THAN 18 YEARS OF AGE:</b> <ul style="list-style-type: none"><li><input type="checkbox"/> Request for a dose increase of previously approved medication</li><li><input type="checkbox"/> Prescribed by or in consultation with a child development pediatrician, general psychiatrist (only if member is older than 14 years old), child &amp; adolescent psychiatrist or pediatric neurologist: _____</li></ul>			

- ☐ 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.)