

## **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		<u>;</u> ):		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							
Requests for all non-preferred medicati have a history of trial and failure of or cont to the preferred Antipsychotics? Refer to his drug-list for a list of preferred and non-prefer class.	raindication or into ttps://papdl.com/pr	olerance r <u>eferred</u> -	Vac	Medications taken (start and end date and dose):			
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							
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.							
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:							

	to: Aut	er has severe behavioral problems related to ps cism spectrum disorder, Intellectual disability, C	onduct disorder, Bipolar disease, Tic disor	der (including			
		rette's syndrome), Transient encephalopathy, Schizophrenia: mber has had a comprehensive evaluation as evident by chart notes					
		ther has find a comprehensive evaluation as evident by chart notes therefore the same and family based therapies) as evident by					
		notes:					
		er has the following baseline and/or follow-up r	nonitoring. Check all that apply and subm	it documentation for			
		BMI (or weight and height):					
		Blood pressure:					
		Fasting glucose level/A1c:					
		Fasting lipid panel:					
		Presence of extrapyramidal symptoms (EPS) u (AIMS):	sing the Abnormal Involuntary Movement	Scale			
RENEW	AL RE	QUESTS FOR A MEMBER LESS THAN 18 YEAR	S OF AGE:				
	Memb each.	er has the following baseline and/or follow-up r	nonitoring. Check all that apply and subm	it documentation for			
		Improvement in target symptoms evident by:_					
		BMI or weight monitored quarterly:					
		Blood pressure:					
		Fasting glucose level/A1c:					
		Fasting lipid panel:					
		Presence of extrapyramidal symptoms (EPS) u first 3 months then annually:					
		Plan for taper/discontinuation of the Antipsych					
		QUESTS FOR A MEMBER 18 YEARS OF AGE OF					
		nentation of tolerability and experienced a posit	• •				
	by:			<del></del>			
IV. AD	DITIC	NAL RATIONALE FOR REQUEST / PERTI	NENT CLINICAL INFORMATION:				
		linical information to support the request on edical 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.)