ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM *(effective 1/5/2026)*

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/

Prior authorization guidelines for **Antipsychotics** and **Quantity Limits/Daily Dose Limits** guidelines are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐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:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form (tablet, solution, etc.):	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Diagnosis code (*required*):	
Is the member currently being treated with the requested medication?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		

Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a NON-PREFERRED Antipsychotic:

☐The member tried and failed or has a contraindication or an intolerance (such as diabetes, obesity, etc.) to the preferred Antipsychotics (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐If the request is for **Opipza (aripiprazole) film,** the member has a contraindication or intolerance to aripiprazole ODT that would not be expected to occur with Opipza film

2. For an Antipsychotic for a child UNDER THE AGE OF 18 YEARS:

☐Is prescribed the Antipsychotic by or in consultation with one of the following specialists:

- ☐a child development pediatrician
- ☐a child & adolescent psychiatrist
- ☐a general psychiatrist (only if member is ≥14 years of age)
- ☐a pediatric neurologist

☐Has severe symptoms related to psychotic or neurodevelopmental disorders such as seen in the following diagnoses:

- ☐autism spectrum disorder
- ☐bipolar disorder
- ☐mood disorders with psychotic features
- ☐schizophrenia & schizophrenia-related disorders

☐conduct disorder ☐tic disorder (including Tourette's syndrome)
☐intellectual disability ☐transient encephalopathy

☐Has chart documented evidence of a comprehensive evaluation

☐Has a documented plan of care that includes non-pharmacologic therapies (eg, evidence-based behavioral, cognitive, and family-based therapies) when indicated according to national treatment guidelines

☐**For an Antipsychotic with risk of metabolic changes:** Has documented baseline monitoring of the following:

☐blood pressure ☐extrapyramidal symptoms using Abnormal Involuntary Movement Scale (AIMS)
☐fasting lipid panel ☐weight or BMI
☐fasting glucose or HbA1c

RENEWAL requests for a child UNDER THE AGE OF 18 YEARS

1. **For an Antipsychotic for a child UNDER THE AGE OF 18 YEARS:**

☐Has documented improvement in target symptoms

☐**For an Antipsychotic with risk of metabolic changes:** Has documented quarterly monitoring of weight or BMI

☐**For an Antipsychotic with risk of metabolic changes:** Has documented monitoring of the following after the first 3 months of therapy and annually thereafter:

☐blood pressure ☐fasting glucose or HbA1c
☐fasting lipid panel ☐extrapyramidal symptoms using Abnormal Involuntary Movement Scale (AIMS)

☐Has a documented plan for taper/discontinuation of the Antipsychotic drug

☐Has a documented rationale for continued use of the Antipsychotic drug

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber 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.)