



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? (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)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
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.		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		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): <ul style="list-style-type: none"> <input type="checkbox"/> For an atypical antipsychotic, member is being titrated to or tapered from another atypical antipsychotic <input type="checkbox"/> For a typical antipsychotic, member is being titrated to or tapered from another typical antipsychotic <input type="checkbox"/> Member has a medical reason for concomitant use of the requested medications. _____ 			
Quantity Limit: <input type="checkbox"/> If requesting for daily quantity exceeding daily limit (Refer to https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information: _____ _____			
SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.			
REQUEST FOR A MEMBER LESS THAN 18 YEARS OF AGE: <ul style="list-style-type: none"> <input type="checkbox"/> Request for a dose increase of previously approved medication <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 & 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
- 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/A1c: _____
 - 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/A1c: _____
 - 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 rationale 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:
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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.)