

ATYPICAL ANTIPSYCHOTIC

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date _____

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication **NEW** or a **CONTINUATION of THERAPY** ? If so, start date: _____

Is this patient currently hospitalized? **Yes** **No**

SECTION B - PHYSICIAN INFORMATION

First Name:	Last Name:	M.D./D.O.
Address:		City: State: Zip:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax Attention to:		

SECTION C - MEDICAL INFORMATION

Medication:	Strength:
Directions for use:	
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:

For Therapeutic Duplication Requests:
 Is The requested medication being prescribed because the patient is switching from one antipsychotic medication to another?
 Yes or No (Circle Answer) If Yes, reason: _____
 Is the requested medication being added to current antipsychotic therapy and will the patient remain on both drugs?
 Yes or No (Circle Answer) If Yes, reason: _____
 Is there a reason or special circumstance that the patient will be taking two or more antipsychotic medications?
 Yes or No (Circle Answer) If Yes, reason: _____

For Non Preferred Drug Requests:
 Did the patient exhibit an inadequate response to previous treatment with all preferred antipsychotics?
 (Risperidone, ziprasidone, olanzapine, quetiapine)
 Yes or No (Circle Answer) If Yes, explain _____
 Did the patient exhibit an intolerance or adverse reaction to previous therapy with all preferred antipsychotics?
 (Risperidone, ziprasidone, olanzapine, quetiapine)
 Yes or No (Circle Answer) If Yes, explain _____

For Quantity Limit Requests:
 Please provide clinical rationale for the requested quantity: _____

Additional clinical information to support this request:

Other Medications tried				
Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: _____ **Date:** _____

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