

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION REQUEST FORM*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.

Drug Name: **Seroquel® (quetiapine), Abilify® (aripiprazole), Geodon® (ziprasidone), Risperdal®**

Drug Requested (pick one):

- Seroquel®
- Abilify®
- Geodon®
- Risperdal®

Diagnosis _____

AND

Reason for Request

(pick at least one of the following to justify use of one of the above agents over risperidone):

- Patient enrolled with Optima Health within the past three months and was stable on Seroquel®, Abilify®, Geodon®, or Risperdal® prior to enrollment (subject to verification by Optima Health)
- Patient is taking a cholesterol-lowering medication
- Patient is taking a medication for diabetes
- Patient is taking a medication for Parkinson's disease
- Patient is taking a medication to treat or prevent osteoporosis
- Patient has a history of breast cancer and is taking one of the following medications: Arimidex®, Aromasin®, Femara®, Tykerb®, tamoxifen, or toremifene
- Patient has a history of pituitary tumor and is taking one of the following medications: cabergoline or bromocriptine
- Patient has tried and failed risperidone
- Other reason (please specify) _____

Patient Name _____

Member Number _____

Physician Signature _____

Date _____

Physician Name _____ Phone Number _____

Fax Number _____

Pharmacy Name _____ Pharmacy Tel # _____