Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Atypical Antipsychotics Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? _____

ICD-10 Code(s): _____

Medication history:

Select if the patient has tried and failed at least 30 days of therapy with the following medications:

- ❑ Aripiprazole
- ❑ Olanzapine
- ❑ Quetiapine
- ❑ Risperidone
- ❑ Ziprasidone

Quantity limit requests:

What is the quantity requested per DAY? _____

Previous therapies failed and/or therapies currently used in combination with the requested medication (*List ALL medications tried or authorization process will be delayed)*:_____

_____

_____

Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? ❑ **Yes** ❑ **No**

If **Yes**, please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature).

*** Please note: Chart documentation of the above is required to be submitted along with this fax*

_____

_____

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Prescriber Signature:_____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.