



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 <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>
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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 <u>30 days</u> of therapy with the following medications: <input type="checkbox"/> Aripiprazole <input type="checkbox"/> Olanzapine <input type="checkbox"/> Quetiapine <input type="checkbox"/> Risperidone <input type="checkbox"/> Ziprasidone
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Quantity limit requests: What is the quantity requested per DAY? _____ Previous therapies failed and/or therapies currently used in combination with the requested medication <i>(List ALL medications tried or authorization process will be delayed)</i> : _____ _____ Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> 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). <i>** Please note: Chart documentation of the above is required to be submitted along with this fax</i> _____ _____

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.

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