ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM
(form effective 1/8/2024)

Keystone First Community HealthChoices | PerformRx[SM] Next Generation Pharmacy Benefits

Fax to PerformRx[SM] at **1-855-851-4058**, or to speak to a representative, call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request | Total pages: | Office contact/phone: | LTC facility contact/phone:

PATIENT INFORMATION

Patient name: | Patient ID#: | DOB:

Street address: | Apt #: | City/state/zip:

PRESCRIBER INFORMATION

Prescriber name:

Specialty: | NPI: | State license #:

Street address: | Suite #: | City/state/zip:

Phone: | Fax:

MEDICATION REQUESTED

Preferred Agents

☐ Abilify Asimtufii
☐ Abilify Maintena
☐ aripiprazole tablet
☐ Aristada ER injection
☐ Aristada Initio injection
☐ clozapine tablet
☐ fluphenazine oral concentrate
☐ fluphenazine tablet
☐ fluphenazine decan. inj.
☐ haloperidol tablet
☐ haloperidol decanoate inj.
☐ haloperidol lactate inj.
☐ haloperidol lactate oral concentrate
☐ Invega Hafyera
☐ Invega Sustenna
☐ Invega Trinza
☐ loxapine capsule
☐ lurasidone tablet
☐ olanzapine tablet
☐ paliperidone ER tab
☐ perphenazine tablet
☐ Perseris ER injection
☐ quetiapine tablet
☐ quetiapine ER tablet
☐ Risperdal Consta
☐ risperidone solution
☐ risperidone tablet
☐ trifluoperazine tablet
☐ ziprasidone capsule
☐ Zyprexa Relprevv

Non-Preferred Agents

☐ Abilify Mycite
☐ Abilify tablet
☐ Adasuve inhalation
☐ amitriptyline/perphenazine
☐ aripiprazole ODT
☐ aripiprazole solution
☐ asenapine SL
☐ Caplyta capsules
☐ chlorpromazine inj.
☐ chlorpromazine solution
☐ chlorpromazine tablet
☐ clozapine ODT
☐ Clozaril tablet
☐ Fanapt tablet
☐ fluphenazine elixir
☐ fluphenazine HCl injection
☐ Geodon capsule
☐ Geodon injection
☐ Haldol decanoate inj.
☐ Invega ER tablet
☐ Latuda tablet
☐ Lybalvi
☐ molindone tablet
☐ Nuplazid capsule
☐ Nuplazid tablet
☐ olanzapine inj/ODT
☐ olanzapine/fluoxetine cap
☐ pimozide tablet
☐ Rexulti tablet
☐ Risperdal solution/tablet
☐ risperidone ODT
☐ Saphris SL tablet
☐ Secuado patch
☐ Seroquel tablet
☐ Seroquel XR tablet
☐ Symbyax capsule
☐ thioridazine tablet
☐ thiothixene capsule
☐ Uzedy ER
☐ Versacloz suspension
☐ Vraylar capsule
☐ Ziprasidone inj.
☐ Zyprexa tablet/injection
☐ Zyprexa Zydis
☐ other:

Strength: | Dosage form: | Directions: | Quantity: | Refills:

Diagnosis: | Diagnosis code (required):

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #: | Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

REQUEST FOR A NON-PREFERRED AGENT

1. Has the patient taken the requested non-preferred antipsychotic in the past 90 days? ☐ Yes – *Submit documentation.* ☐ No
2. Has the patient tried and failed the preferred medications (listed above)? ☐ Yes – List medications tried: ☐ No
3. Does the patient have a contraindication or intolerance to the preferred medications? ☐ Yes – *Submit documentation of contraindication/intolerance.* ☐ No

REQUEST FOR A PATIENT LESS THAN 18 YEARS OF AGE

4. For renewal requests, has the patient had improvement in target symptoms with use of this medication? ☐ Yes ☐ No
5. Is this request for a dose increase of a previously approved medication or request over the plan limits? ☐ Yes – *Submit recent chart documentation and/or treatment guidelines supporting the requested dose.* ☐ No
6. For renewal requests, is there a plan for taper/discontinuation or rationale for continued use of requested drug ? ☐ Yes Submit supporting documentation. ☐ No
7. Is the requested agent prescribed by, or in consultation with, one of the following physician specialists? ☐ Yes ☐ No *Submit documentation of consultation, if applicable.*
   ☐ child development pediatrician ☐ child & adolescent psychiatrist ☐ general psychiatrist (only if patient is ≥ 14 years of age) ☐ pediatric neurologist
8. Does the patient have severe symptoms related to a psychotic or neuro-developmental disorder? ☐ Yes – *Submit medical record documentation.* ☐ No
9. Has chart documented evidence of comprehensive evaluation and plan of care that includes non-drug therapies? ☐ Yes – *Submit medical record documentation.* ☐ No
10. Has the patient had the following baseline and/or follow-up monitoring? Check all that apply. ☐ BMI and/or weight (for follow-up monitoring this must be done quarterly) ☐ blood pressure ☐ fasting blood glucose or hemoglobin a1c ☐ fasting lipid panel ☐ presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)
    Submit documentation of all monitoring/test results and dates.

REQUEST FOR THERAPEUTIC DUPLICATION OF AN ATYPICAL OR TYPICAL ANTIPSYCHOTIC

11. Does the patient have a medical reason for concomitant use of the requested medications? ☐ Yes – *Submit documentation of treatment guidelines supporting concomitant use.* ☐ No
12. Is this request for a drug that is being titrated to, or tapered from, a drug in the same class? ☐ Yes ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature: | Date:

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