ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM

(form effective 1/5/21)

Keystone First | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-215-937-5018**, or to speak to a representative call **1-800-588-6767**.

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

Non-Preferred Agents

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

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	**4. For oral Invega/paliperidone ER requests, does the patient have active liver disease with elevated LFTs or is the patient at risk for active liver disease?** ☐ Yes – *Submit documentation and lab values.* ☐ No

REQUEST FOR A PATIENT LESS THAN 18 YEARS OF AGE

5. Is this request for a dose increase of a previously approved medication? ☐ Yes – *Submit recent chart documentation supporting the increased dose.* ☐ No

6. 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

7. Does the patient have severe behavioral problems related to a psychotic or neuro-developmental disorder? ☐ Yes – *Submit medical record documentation.* ☐ No

8. Has the patient tried non-drug therapies? ☐ Yes – *Submit medical record documentation.* ☐ No

9. Has the patient had the following baseline and/or follow-up monitoring? Check all that apply. ☐ BMI (or weight/height) ☐ blood pressure ☐ fasting glucose level ☐ fasting lipid panel
☐ presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)
Submit documentation of all monitoring/test results.

REQUEST FOR A LOW-DOSE ORAL ANTIPSYCHOTIC FOR A PATIENT 18 YEARS OF AGE OR OLDER

10. What is the TOTAL daily dose of the requested medication? _____mg/day
Submit documentation of complete medication regimen.

11. Is the low dose prescribed as part of a plan to titrate up to a therapeutic dose? ☐ Yes – *Submit documentation of titration plan.* ☐ No

REQUEST FOR THERAPEUTIC DUPLICATION OF AN ATYPICAL OR TYPICAL ANTIPSYCHOTIC

12. Does the patient have a medical reason for concomitant use of the requested medications? ☐ Yes – *Submit documentation with justification.* ☐ No

13. Is this request for a drug that is being titrated to, or tapered from, a drug in the same class? ☐ Yes – *List medication.* ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: