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

Community HealthChoices | AmeriHealth Caritas Pennsylvania | PERFORMRX℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative, call **1-888-674-8720**.

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

Non-Preferred Agents

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

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: