MARYLAND Department of Health

Maryland Medicaid Pharmacy Program

Antipsychotic Prior Authorization Form

For Patients 18 Years of Age and Older

Phone: (800) 932-3918 Fax: (866) 440- 9345

Prescriber's Information			
Name:	NPI #	Degree:	Specialty:
Mailing Address, City, State & Zip:			
Telephone:	Fax:	Email Address:	

Patient's Information		
Name:	DOB:	MA #

DSM Diagnosis (Check All That Apply)

❑ ADHD	❑ Intellectual Disability	❑ PTSD
❑ Anti-Social or Borderline Personality D/O	❑ Major Depressive Disorder	❑ Schizoaffective Disorder
❑ Autism Spectrum Disorder	❑ Obsessive Compulsive Disorder	❑ Schizophrenia
❑ Bipolar Disorder	❑ Panic Disorder	❑ Social Phobia
❑ Conduct or Oppositional Defiant D/O	❑ Psychotic D/O – Not Schizophrenia	❑ Tourette's Disorder
❑ Dementia	(Specify): _____	❑ Other
❑ Generalized Anxiety Disorder		(Specify): _____

Target Symptoms

❑ Aggression	❑ Depression	❑ Irritability	❑ Self-Injurious Behaviors
❑ Assault	❑ Hallucinations	❑ Mania	❑ Other(s)
❑ Delusion	❑ Insomnia	❑ Mood Lability	(Specify):

Tier II Preferred	Non-Preferred			
❑ Latuda®	❑ Adasuve® ❑ Aristada® ❑ clozapine ODT ❑ Fanapt®	❑ Invega® ❑ Nuplazid ® ❑ olanzapine/fluoxetine ❑ Rexulti ®	❑ Saphris ® ❑ Versacloz ® ❑ Vraylar ® ❑ Zyprexa Relprevv®	❑ Other
Dosage Form:	Strength:	Frequency:	Quantity:	

❑ There is a plan to discontinue or taper an antipsychotic for this patient. Specify Antipsychotic: _____

Quantity Limit: (If Request is Outside the FDA Maximum For Dose and/or Frequency)

❑ Dose is Being Titrated ❑ Failed FDA Recommended Regimen (Describe Failed Regimen) ❑ Other (Explain Rationale)	Description or Rationale:

Is the requested medication a continuation of therapy from an **Inpatient** setting? ❑ Yes - **Discharge Date:** _____ ❑ No

Is the requested medication a continuation of therapy from an **Outpatient** setting? ❑ Yes - **Start Date:** _____ ❑ No

If the patient has a drug/drug interaction or condition that prevents using a Preferred drug, please explain: _____

_____

Prior Mental Health Medication Trials? ❑ Yes ❑ No If Yes, please specify below.

Medication	Strength	Frequency	Duration of Treatment	Is Patient compliant at least 6 days a week?	Reason Discontinued
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ No	

I certify that the benefits of antipsychotic treatment for this patient outweigh the risks, and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber Signature _____ **Date** _____