MARYLAND MEDICAID PHARMACY PROGRAM
TEL: 1-855-283-0876
FAX: 1-866-671-8084

REQUEST TO AUTHORIZE ANTIPSYCHOTIC PRESCRIPTION FOR YOUTH 17 AND YOUNGER

Prescriber Information

Prescriber Name: ________________ ________________ ____
Last name *First name* *MI*

Mailing Address: ____

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Email Address: ____

NPI Number: ______________________ Tel: ________________

Medical Specialty: __________________ Fax: ________________

Alternate Contact (if applicable):____________________________

Patient Information

Patient Name: ____________________________ ________________________ ____
Last name *First name* *MI*

Patient MA #: ____ ☐ Male ☐ Female

DOB (mm/dd/yyyy): ________________

Height (inches):_______ Date:_________

Weight (pounds):______ Date:________

DSM Diagnosis (check all that apply)

- ☐ ADHD
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disorder
- ☐ Conduct or Oppositional Defiant Disorder
- ☐ Disruptive Mood Dysregulation Disorder
- ☐ Generalized Anxiety Disorder
- ☐ Intellectual Disability
- ☐ Major Depressive Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Panic Disorder
- ☐ Psychotic Disorder – not schizophrenia (specify)______________________
- ☐ Post Traumatic Stress Disorder
- ☐ Reactive Attachment Disorder
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Substance Related/Addictive Disorder
- ☐ Tourettes Disorder
- ☐ Other:______________________

Non-DSM Disorder

- ☐ Traumatic Brain Injury

Target Symptoms (check all that apply)

- ☐ Aggression
- ☐ Anxiety
- ☐ Assault
- ☐ Delusion
- ☐ Depression
- ☐ Hallucinations
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Insomnia
- ☐ Irritability
- ☐ Mania
- ☐ Mood instability
- ☐ Self-injurious behavior
- ☐ Other symptoms (specify):

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The checked symptoms place the child at risk of:

- ☐ hospitalization
- ☐ out of home placement
- ☐ suspension/expulsion from school
- ☐ danger to self
- ☐ danger to others
- ☐ none of the above

Laboratory Values, ECG and Rating Scale

Fasting Glucose:
Date:_________
Value:_______

Fasting Lipids:
Date:_________
Triglycerides:_________
LDL:_________
HDL:______________

Abnormal Involuntary Movement Scale:
Date:_________
Score:_______

Hepatic Function:
Date:_________
Alk. Phos.:_________
AST:_________
ALT:____________

A BASELINE ECG IS REQUIRED FOR ALL PATIENTS RECEIVING ZIPRASIDONE OR IF A PATIENT HAS HISTORY OF ANY OF THE FOLLOWING:

Personal history of syncope, palpitation cardiovascular abnormalities ☐yes ☐no
Positive family history of sudden death/cardiovascular abnormalities ☐yes ☐no

ECG Results (when applicable)

Date: ____________ ☐ normal ☐ QTc value(msec): ____________

☐ other ECG abnormality (specify): ______________________________

Please provide an explanation for any missing laboratory information: ____

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Non-Pharmacologic Treatment and Other Clinical Information

The patient is currently receiving non-pharmacologic/psychosocial services. ☐ yes ☐ no ☐ referred and appointment pending

Please specify the type of non-pharmacologic/psychosocial services: ________________________________

The patient has been recently treated in an inpatient, emergency or crisis setting. ☐ yes ☐ no date of discharge ________________

The patient has a history of known abuse or trauma. ☐ yes ☐ no

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Patient Name:____

Antipsychotic for which authorization is being sought (check)

Preferred	Preferred	Preferred	Tier 2 Preferred	Non-Preferred	Non-Preferred
☐ Abilify ®	☐ perphenazine	☐ thioridazine	☐ Abilify Maintena ®	☐Abilify ® IM	☐ Olanzapine/Fluoxetine
☐chlorpromazine	☐ pimozide	☐ thiothixene	☐ Latuda ®	☐ Clozapine ODT	☐ Saphris ®
☐clozapine	☐quetiapine	☐ trifluoperazine	☐ olanzapine	☐ Fanapt ®	☐ Seroquel XR ®
☐ fluphenazine	☐ risperidone	☐ ziprasidone		☐ Invega ®	☐ Zyprexa Relprevv ®
☐ haloperidol					

Antipsychotic:________________________ Strength:_______________Regimen:______________________________ Total Daily Dose:________

Antipsychotic:________________________ Strength:_______________Regimen:______________________________ Total Daily Dose:________

☐ There is a plan to discontinue or taper an antipsychotic in this patient (specify antipsychotic) ________________________________

If the dosing regimen varies from FDA approved product labeling, please explain the reason why this is necessary: _________________________

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Additional Medication Use and History

List the details of trials with other antipsychotics (if any):

Antipsychotic Name	Strength/Frequency	Approximate Dates of Trial	Response/Reason for Discontinuation

List any other psychopharmacologic agents the patient is receiving(if any):

Medication	Strength/Frequency	Approximate Dates of Trial	Indication

Continuation and Certification

It is likely that this patient will be transferred to the care of another provider. ☐ yes ☐ no If yes, to whom? ___________________________

I certify that the benefits of antipsychotic treatment for this patient outweigh the risks of treatment.

Prescriber Signature:____ Date:______________________