Maryland Medicaid Pharmacy Program

Antipsychotic Prior Authorization Form

For Patients 18 Years of Age and Older

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

DHMH

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
- ☐ Anti-Social or Borderline Personality D/O
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disorder
- ☐ Conduct or Oppositional Defiant D/O
- ☐ Dementia
- ☐ Generalized Anxiety Disorder
- ☐ Intellectual Disability
- ☐ Major Depressive Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Panic Disorder
- ☐ Psychotic D/O – Not Schizophrenia

(Specify) _____

- ☐ PTSD
- ☐ Schizoaffective Disorder
- ☐ Schizophrenia
- ☐ Social Phobia
- ☐ Tourette's Disorder
- ☐ Other (Specify) _____

Target Symptoms

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

Antipsychotic for Which Authorization is Being Sought

Tier II Preferred

- ☐ Abilify®
- ☐ Latuda®
- ☐ olanzapine

Non-Preferred

- ☐ Abilify® IM
- ☐ clozapine ODT
- ☐ Fanapt®
- ☐ Invega®
- ☐ olanzapine/fluoxetine
- ☐ Saphris ®
- ☐ Seroquel XR ®
- ☐ Zyprexa Relprevv®

Dosage Form: Select	Strength:	Frequency:	Quantity:
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☐ 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.

Prescriber Signature _____ **Date** _____