STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Maryland Medical Assistance Program
Pharmacy Transmittal No. 197
July 31, 2012

TO: Prescribers of Antipsychotic Medication

FROM: Athos Alexandrou, Director
Pharmacy Services

Susan Tucker, Executive Director
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organizations are informed of the contents of this transmittal.

RE: Changes to the Prior Authorization Form for Preferred Tier 2 and Non-preferred Antipsychotic Medications

Starting on August 20, 2012, the Maryland Medicaid Pharmacy Program (MMPP) is changing the prior authorization form and criteria used for approval of preferred tier 2 and non-preferred antipsychotic medications. A copy of the new form is attached. You can also find an electronic version of the form on the MMPP website at: http://mmcp.dhmh.maryland.gov/pap/SitePages/Preferred%20Drug%20List.aspx.

The clinical criteria are also listed on the MMPP website at: http://mmcp.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx .

You are receiving this transmittal because in the past 12 months, you have prescribed an antipsychotic medication to one or more Maryland Medicaid patients.

Questions concerning this transmittal should be directed to the Maryland Medicaid Pharmacy Program at (410) 767-1455.

Attachment

Maryland Medicaid Pharmacy Program

Tel: 1-800-932-3918

Fax: 1-866-440-9345

Tier II and Non-Preferred Antipsychotic Prior Authorization form

Prescriber Information

Prescriber Name: _____ NPI Number: _____

Mailing Address: _____Specialty: _____

Tel: _____ Fax: _____ Email: _____

Patient Information

Patient Name: _____ Patient MA#: _____

Mailing Address: _____

DOB (MM/DD/YY): _____Male ___ Female ___ Height (inches): _____ Weight (pounds): _____

Diagnosis (Current DSM Diagnosis) Please check all that apply				
ADHD	Anti-social or Borderline Person Disorder	Asperger's or PDDNOS	Autistic Disorder	Bipolar Disorder
Conduct or Oppos. Def. Disorder	Dementia	Generalized Anxiety Disorder	Major Depressive Disorder	Mental Retardation
Obsessive Compulsive Disorder	Panic Disorder	Psychotic Disorder - Not Schiz. (specify):_____	PSTD	Schizoaffective Disorder
Schizophrenia	Social Phobia	Tourette's Disorder	Other (specify): _____	

☐ Target Symptoms (check all target symptoms for which drug is being prescribed)				
aggression	delusions	depression	hallucinations	irritability
mania	mood lability	self-injurious behavior	insomnia	other (specify): _____

Antipsychotic for which authorization is being sought: (Check)				
Abilify	**Fanapt**	**Fazaclo**	**Invega**	**Invega Sustenna**
Latuda	**Olanzapine IM**	**Olanzapine**	**Saphris**	**Seroquel XR**
Symbyax	**Ziprasidone**	**Zyprexa Relprevv**		

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Tier II and Non-Preferred Antipsychotic Prior Authorization form

Dosage Form: _____ **Strength:** _____ **Frequency:** _____ **Quantity:** _____

Dosage Form: _____ **Strength:** _____ **Frequency:** _____ **Quantity:** _____

Was the patient discharged from the inpatient setting on requested medication? Yes No

Does the patient have a condition that prevents the use of the preferred medication? Yes No

If yes, please specify: _____

Is there a drug-drug interaction between another medication and the preferred medication? Yes No

If yes, please specify: _____

Has the patient experienced treatment failure with other medications? Yes No

If yes, please list which medications the patient has tried:

Medication Name	Strength/Frequency	Date Used	Compliance (at least 6 days/wk)	Reason for Discontinuation
			Yes No	
			Yes No	
			Yes No	