Maryland
DEPARTMENT OF HEALTH

Maryland Medicaid
Office of Pharmacy Services
Tel: 1-855-283-0876
Fax:1-833-485-2524

Request to Authorize Oral Antipsychotic Prescription for Youth 17 and Younger

Incomplete forms will be returned

Patient Information

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

DOB (mm/dd/yyyy): ____________________

Height (inches):_________ Date:__________

Maryland Medicaid #: ____

Weight (pounds):________Date:__________

☐ Male ☐ Female

Prescriber Information

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

NPI #: ______________________

Treatment site or office address: _____________________________

Tel:________________________

____

Treatment site or office fax: ______________________

Medical Specialty: ____________________________________

Email address: _______________________________

Alternate Contact (if applicable):___________________________

Antipsychotic for which authorization is being sought (please check)

1st Tier Preferred

☐ aripiprazole
☐ aripiprazole ODT
☐ chlorpromazine
☐ clozapine
☐ fluphenazine
☐ haloperidol
☐ loxapine
☐ lurasidone
☐ olanzapine
☐ olanzapine ODT
☐ paliperidone
☐ perphenazine
☐ perphenazine/amitriptyline
☐ pimozide
☐ quetiapine
☐ quetiapine ER
☐ risperidone
☐ risperidone ODT
☐ thioridazine
☐ thiothixene
☐ trifluoperazine
☐ ziprasidone

2nd Tier Preferred

☐ *Vraylar*

Non-Preferred

☐ asenapine
☐ clozapine ODT
☐ molindone
☐ olanzapine/fluoxetine
☐ *Abilify MyCite*
☐ *Adasuve*
☐ *Caplyta*
☐ *Fanapt*
☐ *Lybalvi*
☐ *Nuplazid*
☐ *Rexulti*
☐ *Rykindo*
☐ *Secuado*
☐ *Versacloz*

If requesting a long-acting injectable antipsychotic, please use the *Request to Authorize Long-Acting Antipsychotic Injection (LAI) Prescription for Youth 17 and Younger* available here https://health.maryland.gov/mmcp/pap/pages/peer-review-program.aspx

Antipsychotic:___________________Strength:____________Regimen:_________________________ Total Daily Dose: ________

Antipsychotic:___________________Strength:____________Regimen:_________________________ Total Daily Dose:________

☐ The patient was recently treated in an inpatient, emergency or crisis setting. If so, date of discharge: ________________

☐ This is a continuation or inpatient or emergency treatment. If so, date of initiation of antipsychotic: _________________

☐ 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 why this is necessary: ____________________________

____

DSM Diagnosis (please check all that apply)

☐ Attention-Deficit/Hyperactivity Disorder (ADHD)
☐ Autism Spectrum Disorder
☐ Bipolar Disorder
☐ Conduct Disorder
☐ Disruptive Mood Dysregulation Disorder (DMDD)
☐ Generalized Anxiety Disorder
☐ Intellectual Disability
☐ Major Depressive Disorder
☐ Obsessive Compulsive Disorder
☐ Oppositional Defiant Disorder
☐ Panic Disorder
☐ Psychotic Disorder (other)
Specify __________________
☐ Post-Traumatic Stress Disorder
☐ Reactive Attachment Disorder
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Schizophreniform Disorder
☐ Substance Use Disorder
☐ Tourette Syndrome
☐ Traumatic Brain Injury
☐ Other Disorder
Specify _______________________

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Patient Name:____

Target Symptoms (please check all that apply)

☐ Aggression
☐ Anxiety
☐ Assault
☐ Delusions
☐ Depression

☐ Hallucinations
☐ Hyperactivity
☐ Impulsivity
☐ Insomnia
☐ Irritability

☐ Mania
☐ Mood instability
☐ Self-injurious behavior
☐ Other Symptoms (Specify)
____
____

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:__________
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:____
____

Non-Pharmacologic Treatment and Other Clinical Information

The patient is currently receiving non-pharmacologic/psychosocial services (may include school-based services).
☐yes ☐no ☐referred and appointment pending

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

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

Other Psychopharmacologic Agents the Patient is Receiving

Medication	Strength/Frequency	Approximate Dates of Trial	Indication

Previous Antipsychotic Trials

Medication	Strength/Frequency	Approximate Dates of Trial	Indication

Continuation of Care 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 and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber Signature:____ Date:____________________

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.