



Antipsychotic Prior Authorization Form
For Patients 18 Years or Older
Incomplete forms will not be reviewed

Maryland Medicaid
Office of Pharmacy Services
 Phone: (833) 325-0105
 Fax: (866) 440-9345

Date (DD/MM/YYYY): _____

Patient Information

Name: _____ DOB (DD/MM/YYYY): _____ M F

Medicaid Assistance Number: _____ Height: _____ Weight: _____ BMI: _____

Prescriber Information

Name: _____ NPI: _____ Specialty: _____

Contact Person: _____ Phone: _____ Fax: _____

Diagnostic and Statistical Manual of Mental Disorders (DSM) Diagnosis (please check all that apply)

<input type="checkbox"/> ADHD <input type="checkbox"/> Anti-Social or Borderline Personality Disorder <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Conduct or Oppositional Defiant Disorder <input type="checkbox"/> Dementia	<input type="checkbox"/> Generalized Anxiety Disorder <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Major Depressive Disorder <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Psychotic Disorder – Not Schizophrenia (Specify): _____	<input type="checkbox"/> PTSD <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Social Phobia <input type="checkbox"/> Tourette’s Disorder <input type="checkbox"/> Other Disorder (Specify): _____
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Target Symptoms (please check all that apply)

<input type="checkbox"/> Aggression <input type="checkbox"/> Assault <input type="checkbox"/> Delusion	<input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Insomnia	<input type="checkbox"/> Irritability <input type="checkbox"/> Mania <input type="checkbox"/> Mood instability	<input type="checkbox"/> Self-Injurious Behaviors <input type="checkbox"/> Other(s) (Specify): _____
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Requested Antipsychotic

Tier II Preferred	Non-Preferred			
<input type="checkbox"/> Vraylar® <input type="checkbox"/> Other: _____	<input type="checkbox"/> Adasuve® <input type="checkbox"/> amitriptyline/perphenazine <input type="checkbox"/> asenapine <input type="checkbox"/> Caplyta®	<input type="checkbox"/> Cobenfy® <input type="checkbox"/> clozapine ODT <input type="checkbox"/> Erzofri® <input type="checkbox"/> Fanapt® <input type="checkbox"/> Lybalvi®	<input type="checkbox"/> molindone <input type="checkbox"/> Nuplazid® <input type="checkbox"/> olanzapine/fluoxetine <input type="checkbox"/> Rexulti® <input type="checkbox"/> Secuado®	<input type="checkbox"/> Versacloz® <input type="checkbox"/> Zyprexa Relprevv® <input type="checkbox"/> Other: _____

Dosage form: _____ Strength: _____ Frequency: _____ Quantity: _____

Rationale of the request: _____
 Plan to discontinue or taper an antipsychotic for this patient? Please specify: _____
 Is it a continuation of therapy from an Inpatient? If Yes, Discharge Date (DD/MM/YYYY): _____ No

Previous psychotropic trials

Medication	Strength	Frequency	Treatment duration	Patient complaint at least 6days/week?	Reason discontinued
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____

I attest that:

- Prescriber specialty: psychiatrists and other providers with expertise in psychopharmacology.
- Baseline and subsequent evaluation and monitoring will be completed (e.g. CMP/CBC, baseline evaluation for metabolic monitoring – hyperglycemia/diabetes, dyslipidemia, weight and/or CYP450 drug interactions).
- 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.
- If the request is for Lybalvi®: the patient has a BMI ≥ 18, has past or current use of olanzapine, has not used short-acting opioids within 7 days or long-acting opioids within 14 days, and is not in opioid withdrawal.
- If the request is for Cobenfy®: provider must taper and discontinue current antipsychotic medications within 90 days of approval and complete baseline and subsequent monitoring of heart rate. Clozapine will be discontinued before Cobenfy® is initiated.
- If the request is for Long Acting Injectable (LAI): tolerability with oral medication has been established and patient is not on any other LAI antipsychotic concurrently.

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.

Prescriber Signature: _____ Date (DD/MM/YYYY): _____