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: _____

Patient Information

Name: _____ DOB: _____ ❑M ❑ F

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

Prescriber Information

Name: _____ NPI: _____ Specialty: _____

Contact Person Name: _____ Phone: _____ Fax: _____

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

❑ ADHD ❑ Anti-Social or Borderline Personality Disorder ❑ Autism Spectrum Disorder ❑ Bipolar Disorder ❑ Conduct or Oppositional Defiant Disorder ❑ Dementia	❑ Generalized Anxiety Disorder ❑ Intellectual Disability ❑ Major Depressive Disorder ❑ Obsessive Compulsive Disorder ❑ Panic Disorder ❑ Psychotic Disorder – Not Schizophrenia (Specify): _____	❑ PTSD ❑ Schizoaffective Disorder ❑ Schizophrenia ❑ Social Phobia ❑ Tourette's Disorder ❑ Other Disorder (Specify): _____

Target Symptoms (please check all that apply)

❑ Aggression ❑ Assault ❑ Delusion	❑ Depression ❑ Hallucinations ❑ Insomnia	❑ Irritability ❑ Mania ❑ Mood instability	❑ Self-Injurious Behaviors ❑ Other(s) (Specify): _____

Requested Antipsychotic

Tier II Preferred	Non-Preferred			
❑ Vraylar ® ❑ Other: _____	❑ Abilify MyCite® ❑ Adasuve ® ❑ Caplyta® ❑ clozapine ODT ❑ Fanapt®	❑ Lybalvi® ❑ molindone ❑ Nuplazid ® ❑ olanzapine/fluoxetine ❑ Rexulti ®	❑ Rykindo ® ❑ asenapine ❑ Secuado ® ❑ Uzedy ® ❑ Versacloz ®	❑ Zyprexa Relprevv ® ❑ amitriptyline/perphenazine ❑ 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: _____ ❑ No

Previous psychotropic trials

Medication	Strength	Frequency	Duration of treatment	Patient compliant at least 6 days/week?	Reason discontinued
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ 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®: BMI ≥ 18 and the patient has a past or current use of olanzapine.**

❑ **If the request is for Cobenfy®: provider must plan to taper and discontinue current antipsychotic medications and complete baseline and subsequent monitoring of heart rate. Clozapine will be discontinued before Cobenfy® is initiated.**

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: _____