Maryland
DEPARTMENT OF HEALTH

Maryland Medicaid Pharmacy Program

Antipsychotic Prior Authorization Form

For Patients 18 Years of Age and Older

Phone: 800 932 3918 Fax: 866 440 9345

Patient Information		
Patient Name:	DOB:	MA #

Prescriber Information			
Prescriber Name:	NPI #	Degree:	Specialty:
Treatment site or office address:			
Tel:	Fax:	Email Address:	

DSM Diagnosis (please check all that apply)

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

Target Symptoms (please check all that apply)

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

Antipsychotic for Which Authorization Is Being Sought (please check)

Tier II Preferred	Non-Preferred			
❑ Vraylar ®	❑ Abilify MyCite®	❑ Lybalvi®	❑ Rykindo ®	❑ Zyprexa Relprevv ®
❑ Other _____	❑ Adasuve ®	❑ molindone	❑ Saphris ®	❑ Other _____
	❑ Caplyta®	❑ Nuplazid ®	❑ Secuado ®	
	❑ clozapine ODT	❑ olanzapine/fluoxetine	❑ Uzedy ®	
	❑ Fanapt®	❑ Rexulti ®	❑ Versacloz ®	
Dosage Form:		Strength:	Frequency:	Quantity:

❑ There is a plan to discontinue or taper an antipsychotic for this patient. Specify Antipsychotic: _____

Rationale for 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 of Rationale:

Is the requested medication a continuation of therapy from an **Inpatient** setting? ❑ Yes - **Discharge Date:** _____ ❑ No

Please provide a clinical Rationale for Prescribing Non-Preferred Medication:

Previous Psychotropic 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 and verify that the information provided on this form is true and accurate to the best of my knowledge.
❑ Patient's lab/test results and clinical data will be evaluated and monitored.

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** _____