Maryland
DEPARTMENT OF HEALTH

Office of Pharmacy Services
Telephone: 1-855-283-0876
Fax: 1-833-485-2524
Alt Fax: 1-410-618-4168

Request to Authorize Long-Acting Antipsychotic Injection (LAI) 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 Number: _____

Weight (pounds): _____ Date: _____

☐ Male ☐ Female

Prescriber Information

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

NPI Number: _____

Phone Number: _____

Treatment site or office address: _____

_____

Treatment site or office fax: _____

Email Address: _____

Medical Specialty: _____

Contact person for this request: _____

LAI Antipsychotic Request Information

Purpose of Request: ☐ Start an LAI ☐ Continue an LAI that the patient is currently receiving

Which LAI do you wish to prescribe and at what dose? _____

I plan to:
☐ Continue oral antipsychotic indefinitely with the LAI
☐ Continue oral antipsychotic for _____ days for initiation
☐ Discontinue oral antipsychotic immediately after the LAI is administered
☐ The patient is not currently receiving an oral antipsychotic

The Maryland Medicaid Preferred Drug List is located at: https://health.maryland.gov/mmcp/pap/pages/preferred-drug-list.aspx. Antipsychotics are listed under the category: Central Nervous System.

Last injection: Date: _____ Drug: _____ Dose administered: _____

Administered by: _____ Facility: _____

Schedule for the Next Three Injections

Date	Planned Dose	To be administered by/Facility

Current Oral Antipsychotic Regimen

Antipsychotic	Strength	Regimen	Total Daily Dose

☐ This is a continuation of 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): _____

CONTINUED ON NEXT PAGE

Patient Name: _____

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 _____

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 and Rating Scale

Fasting Glucose:
☐ *Check if non-fasting*
Date: _____
Value: _____

Fasting Lipids:
☐ *Check if non-fasting*
Date: _____
Triglycerides: _____
LDL: _____
HDL: _____

Hepatic Function:
Date: _____
AST: _____
ALT: _____

HbA1c:
Date: _____
Value: _____

Abnormal Involuntary Movement Scale:
Date: _____
Score: _____

Please provide an explanation for any missing or abnormal laboratory information: _____
_____

Updated/repeat labs have been ordered: ☐ Yes ☐ No

Non-Pharmacologic Treatment and Other Clinical Information

The patient is currently receiving non-pharmacologic/psychosocial services (e.g. psychotherapy, cognitive behavioral therapy, school-based services, etc.)

☐ Yes ☐ No ☐ Referred and pending ☐ Recommended, but refused or non-adherent

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. MDH and the 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 original signature.

Prescriber Signature: _____ Date: _____

Revised: 2/23/2026