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 Oral Antipsychotic Prescription for Youth 17 and Younger
Incomplete forms will be returned

Patient Information

Patient Name: _____
Last Name *First Name* *MI*

Maryland Medicaid #: _____

☐ Male ☐ Female

DOB (mm/dd/yyyy): _____

Height (inches): _____ Date: _____

Weight: (pounds): _____ Date: _____

Prescriber Information

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

Treatment site or office address: _____
_____

Medical Specialty: _____

Alternate Contact (if applicable): _____

NPI Number: _____

Phone Number: _____

Treatment site or office fax: _____

Email address: _____

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
☐ pimozide
☐ quetiapine
☐ quetiapine ER
☐ risperidone
☐ risperidone ODT
☐ thioridazine
☐ thiothixene
☐ trifluoperazine
☐ ziprasidone

2nd Tier Preferred

☐ *Vraylar*

Non-Preferred

☐ asenapine
☐ clozapine ODT
☐ molindone
☐ olanzapine/fluoxetine
☐ perphenazine/amitriptyline
☐ *Adasuve*
☐ *Caplyta*
☐ *Cobenfy*
☐ *Fanapt*
☐ *Lybalvi*
☐ *Nuplazid*
☐ *Rexulti*
☐ *Secuado*
☐ *Versacloz*

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

Antipsychotic: _____ Strength: _____ Regimen: _____ Total Daily Dose: _____

Antipsychotic: _____ Strength: _____ Regimen: _____ Total Daily Dose: _____

☐ There is a plan to discontinue or taper an antipsychotic in this patient (specify antipsychotic): _____

☐ The patient was recently treated in an inpatient, emergency, or crisis setting. If so, date of discharge: _____
☐ This is a continuation of inpatient or emergency treatment. If so, date of initiation of 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: _____

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):
_____
_____

<u>The checked symptom(s) place the child at risk of</u>:
☐ Hospitalization
☐ Out of home placement
☐ Suspension/expulsion from school
☐ Danger to self
☐ Danger to others
☐ None of the above

Patient name: _____

Laboratory Values, ECG, and Abnormal Involuntary Movement Scale (AIMS)

Fasting Glucose:

Date: _____

Value: _____

Fasting Lipids:

Date: _____

Triglycerides: _____

LDL: _____

HDL: _____

☐ *Check if non-fasting*

Abnormal Involuntary Movement Scale:

Date: _____

Score: _____

Hepatic Function:

Date: _____

AST: _____

ALT: _____

A BASELINE ECG IS REQUIRED FOR ALL PATIENTS RECEVING ZIPRASIDONE AND HAS A 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 ☐ Abnormal
QTc value (msec): _____

☐ Other ECG abnormality (specify): _____

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 appointment pending ☐ Recommended, but refused or non-adherent

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

The patient has a 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.

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