Maryland
DEPARTMENT OF HEALTH

Maryland Medicaid
Office of Pharmacy Services
Tel: 1-855-283-0876
Fax:1-833-485-2524

Request to Authorize Antipsychotic Prescription for Youth 17 and Younger

Patient Information

Patient Name:____
Last name *First name* *MI*

DOB (mm/dd/yyyy): ______________________

Height (inches):__________ Date:____________

Maryland Medicaid #: ____

Weight (pounds):_________Date:____________

☐ Male ☐ Female

Prescriber Information

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

NPI #: ________________________

Tel:__________________________

Treatment site or office address: ________________________________

____

Treatment site or office fax: _______________________

Medical Specialty: _______________________________________

Email address: ___________________________________

Alternate Contact (if applicable):______________________________

Antipsychotic for which authorization is being sought (please check)*

1st Tier Preferred			2nd Tier Preferred	Non-Preferred	
☐ aripiprazole	☐ olanzapine ODT	☐ thiothixene	☐ *Latuda*	☐ asenapine	☐ *Perseris*
☐ aripiprazole ODT	☐ olanzapine	☐ trifluoperazine	☐ *Vraylar*	☐ clozapine ODT	☐ *Rexulti*
☐ chlorpromazine	☐ perphenazine	☐ ziprasidone		☐ molindone	☐ *Secuado*
☐ clozapine	☐ perphenazine/amitriptyline	☐ ziprasidone IM		☐ olanzapine/fluoxetine	☐ *Versacloz*
☐ fluphenazine	☐ pimozide	☐ *Abilify Maintena*		☐ paliperidone	☐ *Zyprexa Relprevv*
☐ fluphenazine decanoate inj	☐ quetiapine	☐ *Aristada*		☐ *Abilify MyCite*	
☐ haloperidol	☐ quetiapine ER	☐ *Aristada Initio*		☐ *Adasuve*	
☐ haloperidol decanoate inj	☐ risperidone	☐ *Invega Sustenna*		☐ *Caplyta*	
☐ loxapine	☐ risperidone ODT	☐ *Invega Trinza*		☐ *Fanapt*	
☐ olanzapine IM	☐ thioridazine	☐ *Risperdal Consta*		☐ *Nuplazid*	

Antipsychotic:____________________Strength:_____________Regimen:____________________________ Total Daily Dose: ________

Antipsychotic:____________________Strength:_____________Regimen:____________________________ Total Daily Dose:________

☐ The patient was recently treated in an inpatient, emergency or crisis setting. If so, date of discharge: __________________

☐ This is a continuation or 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): _________________________

☐ If the dosing regimen varies from FDA approved product labeling, please explain why this is necessary: ______________________________

____

DSM Diagnosis (please check all that apply)

☐ ADHD	☐ Obsessive Compulsive Disorder	☐ Schizophrenia
☐ Autism Spectrum Disorder	☐ Oppositional Defiant Disorder	☐ Schizophreniform Disorder
☐ Bipolar Disorder	☐ Panic Disorder	☐ Substance Related/Addictive Disorder
☐ Conduct Disorder	☐ Psychotic Disorder (other)	☐ Tourette's Disorder
☐ Disruptive Mood Dysregulation Disorder	Specify ___________________	☐ Traumatic Brain Injury
☐ Generalized Anxiety Disorder	☐ Posttraumatic Disorder	☐ Other Disorder
☐ Intellectual Disability	☐ Reactive Attachment Disorder	Specify ________________________
☐ Major Depressive Disorder	☐ Schizoaffective Disorder	

*Please Visit the following website for the latest PDL information: https://health.maryland.gov/mmcp/pap/pages/Preferred-Drug-List.aspx

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Patient Name:____

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, ECG and Rating Scale

Fasting Glucose:
Date:_______________
Value:_______________
Fasting Lipids:
Date:_______________
Triglycerides:__________
LDL:________________
HDL:________________

Abnormal Involuntary Movement Scale:
Date:___________
Score:__________
Hepatic Function:
Date:___________
AST:____________
ALT:____________

A BASELINE ECG IS REQUIRED FOR ALL PATIENTS RECEIVING ZIPRASIDONE OR IF A PATIENT HAS 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 ☐ QTc value(msec): _____________
☐other ECG abnormality (specify): ____________________________________

Please provide an explanation for any missing laboratory information:____
____

Non-Pharmacologic Treatment and Other Clinical Information

The patient is currently receiving non-pharmacologic/psychosocial services (may include school based services).
☐yes ☐no ☐referred and appointment pending

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.

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.