Maryland Medicaid Pharmacy Program ******Complete only for patients age 10 years and older******
Phone: 1-800-932-3918 and Fax: 1-866-440-9345

Tier 2 and Non-Preferred Antipsychotic Prior Authorization Form

Prescriber Information

Prescriber Name: _____NPI #: _____Specialty: _____

Mailing Address: _____

Tel: _____ Fax: _____ Email: _____

Patient Information

Patient Name: _____ Patient MA#: _____

Mailing Address: _____

DOB (MM/DD/YY): _____ Male ___ Female ___ Height (inches): _____ Weight (pounds): _____

DSM - IV - TR Diagnosis (check all that apply)

- ☐ ADHD
- ☐ Anti-social or Borderline Personality D/O
- ☐ Asperger's Disorder or PDDNOS
- ☐ Autistic Disorder
- ☐ Bipolar Disorder
- ☐ Conduct or Oppositional Defiant D/O
- ☐ Dementia
- ☐ Generalized Anxiety Disorder
- ☐ Major Depressive Disorder
- ☐ Mental Retardation
- ☐ Obsessive Compulsive D/O
- ☐ Panic Disorder
- ☐ Psychotic D/O Not Schizophrenia (specify):_____
- ☐ PTSD
- ☐ Schizoaffective D/O
- ☐ Schizophrenia
- ☐ Social Phobia
- ☐ Tourette's Disorder
- ☐ Other (specify): _____

Target Symptoms (check all target symptoms for which drug is being prescribed)

- ☐ Aggression
- ☐ Assault
- ☐ Delusion
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Irritability
- ☐ Mania
- ☐ Mood lability
- ☐ Self-injurious Behavior
- ☐ Other:_____

Antipsychotic for which authorization is being sought: (check)

- ☐ Abilify®
- ☐ Fanapt®
- ☐ Fazaclo®
- ☐ Invega®
- ☐ Invega Sustenna®
- ☐ Latuda®
- ☐ olanzapine
- ☐ olanzapine/fluoxetine
- ☐ Saphris®
- ☐ Seroquel XR®
- ☐ Zyprexa Relprevv®
- ☐ other: _____

Dosage Form: _____**Strength:** _____ **Frequency:** _____**Quantity:** _____

Dosage Form: _____ **Strength:** _____ _____**Frequency:** _____**Quantity:** _____

Is requested medication a continuation of therapy from an inpatient setting? ☐ Yes ☐ No
Does the patient have a condition that prevents the use of the preferred medication? ☐ Yes ☐ No

If yes, please specify: _____

Is there a drug-drug interaction between another medication and the preferred medication? ☐ Yes ☐ No

If yes, please specify: _____

Has the patient experienced treatment failure with other medications? ☐ Yes ☐ No

If yes, please list which medications the patient has tried:

Medication Name	Strength/Frequency	Duration of Treatment	Compliance (at least 6 days/wk)	Reason for Discontinuation

I certify that the benefits of antipsychotic treatment for this patient outweigh the risks.

Prescriber Signature: _____ **Date:** _____

(DHMH Sept. 2012)