pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM *(effective 1/8/2024)*

Prior authorization guidelines for **Antipsychotics** and **Quantity Limits/Daily Dose Limits** guidelines are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Phone of office contact:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form (tablet, solution, etc.):	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Diagnosis code (*required*):	
Is the beneficiary currently being treated with the requested medication?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a NON-PREFERRED Antipsychotic:
   ☐The beneficiary tried and failed or has a contraindication or an intolerance (such as diabetes, obesity, etc.) to the preferred Antipsychotics (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. For an Antipsychotic for a child UNDER THE AGE OF 18 YEARS:
   ☐Is prescribed the Antipsychotic by or in consultation with one of the following specialists:
   - ☐a child development pediatrician
   - ☐a child & adolescent psychiatrist
   - ☐a general psychiatrist (only if beneficiary is ≥14 years of age)
   - ☐a pediatric neurologist

   ☐Has severe symptoms related to psychotic or neurodevelopmental disorders such as seen in the following diagnoses:
   - ☐autism spectrum disorder
   - ☐bipolar disorder
   - ☐conduct disorder
   - ☐intellectual disability
   - ☐mood disorders with psychotic features
   - ☐schizophrenia & schizophrenia-related disorders
   - ☐tic disorder (including Tourette's syndrome)
   - ☐transient encephalopathy

   ☐Has chart documented evidence of a comprehensive evaluation

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☐ Has a documented plan of care that includes non-pharmacologic therapies (eg, evidence-based behavioral, cognitive, and family-based therapies) when indicated according to national treatment guidelines

☐ Has documented baseline monitoring of the following:

- ☐ blood pressure
- ☐ fasting lipid panel
- ☐ fasting glucose or HbA1c
- ☐ extrapyramidal symptoms using Abnormal Involuntary Movement Scale (AIMS)
- ☐ weight or BMI

RENEWAL requests for a child UNDER THE AGE OF 18 YEARS

1. For an Antipsychotic for a child UNDER THE AGE OF 18 YEARS:

☐ Has documented improvement in target symptoms

☐ Has documented quarterly monitoring of weight or BMI

☐ Has documented monitoring of the following after the first 3 months of therapy and annually thereafter:

- ☐ blood pressure
- ☐ fasting lipid panel
- ☐ fasting glucose or HbA1c
- ☐ extrapyramidal symptoms using Abnormal Involuntary Movement Scale (AIMS)

☐ Has a documented plan for taper/discontinuation of the Antipsychotic drug

☐ Has a documented rationale for continued use of the Antipsychotic drug

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: