Physician Request Form for Oral Antipsychotics
Fax to Pharmacy Services at **888-981-5202**, or call **866-610-2774**
to speak to a representative. ***Form must be completed for processing***.

AmeriHealth Caritas Pennsylvania

Patient Name: _____ Patient ID: _____ Date of Birth: _____

Prescriber Name: _____ NPI: _____

Prescriber Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

Contact Name: _____

Prescriber Specialty: ☐Psychiatrist ☐Child/Adolescent Psychiatry ☐Developmental/Behavioral Pediatrics ☐Pediatric Neurology
Prescriber attests that he/she has consulted with one of the specialists above: ☐Yes ☐No

Diagnosis (ICD10): _____

Requested Regimen, Dose and Duration: _____

_____

Initial Authorization
3 Month Approval

1. Patient has received a comprehensive evaluation including baseline monitoring for **ALL** of the following:
   - Weight/BMI
     ☐Yes ☐No
   - Blood Pressure
     ☐Yes ☐No
   - Glucose
     ☐Yes ☐No
   - Lipids
     ☐Yes ☐No
   - Extrapyramidal symptoms (EPS) using the abnormal involuntary movement scale (AIMS)
     ☐Yes ☐No
2. Patient has received a trial of non-pharmacologic therapies (e.g. behavior, cognitive or family based therapies)
   ☐Yes ☐No
3. If patient is receiving duplicate antipsychotics, **ONE** of the following applies:
   ☐Member is being titrated to or tapered from a drug in the same class
   ☐Peer reviewed literature or treatment guidelines support the use of regimen (***Please attach the appropriate clinical documentation if checked**)

Re-Authorization
12 Month Approval

1. Patient has received follow up monitoring of **ALL** of the following within the stated timeframe:
   - Weight/BMI (**quarterly**)
     ☐Yes ☐No
   - Blood Pressure (**after 3 months/then yearly**)
     ☐Yes ☐No
   - Glucose (**after 3 months/then yearly**)
     ☐Yes ☐No
   - Lipids (**after 3 months/then yearly**)
     ☐Yes ☐No
   - Extrapyramidal symptoms (EPS) using AIMS (**after 3 months/then yearly**)
     ☐Yes ☐No
2. Patient has had improvement of symptoms
   ☐Yes ☐No
3. If patient is receiving duplicate antipsychotics, **ONE** of the following applies:
   ☐Member is being titrated to or tapered from a drug in the same class
   ☐Peer reviewed literature or treatment guidelines support the use of regimen (***Please attach the appropriate clinical documentation if checked**)

Additional information for consideration of this request: _____

_____

Deliver to:

☐ Member's Home ☐ Physician's Office ☐ Member's Preferred Pharmacy (Name /Phone #): _____

☐ I acknowledge that the member agrees with the pharmacy chosen for delivery of this medication

Prescriber Signature: _____ **Print Name:** _____ **Date:** _____