



**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)**

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

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

- |                                     |   |  |
|-------------------------------------|---|--|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Mania                   |
| <input type="checkbox"/> Assault    | <input type="checkbox"/> Insomnia       | <input type="checkbox"/> Mood lability           |
| <input type="checkbox"/> Delusion   | <input type="checkbox"/> Irritability   | <input type="checkbox"/> Self-injurious Behavior |
| <input type="checkbox"/> Depression |   | <input type="checkbox"/> Other: _____            |

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Abilify <sup>®</sup> | <input type="checkbox"/> Invega Sustenna <sup>®</sup> | <input type="checkbox"/> Saphris <sup>®</sup>         |
| <input type="checkbox"/> Fanapt <sup>®</sup>  | <input type="checkbox"/> Latuda <sup>®</sup>          | <input type="checkbox"/> Seroquel XR <sup>®</sup>     |
| <input type="checkbox"/> Fazaclo <sup>®</sup> | <input type="checkbox"/> olanzapine                   | <input type="checkbox"/> Zyprexa Relprev <sup>®</sup> |
| <input type="checkbox"/> Invega <sup>®</sup>  | <input type="checkbox"/> olanzapine/fluoxetine        | <input type="checkbox"/> other: _____                 |

Dosage Form: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_

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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: \_\_\_\_\_