MARYLAND MEDICAID PHARMACY PROGRAM
TEL: 1-855-283-0876
FAX: 1-866-671-8084

DHMH

REQUEST TO AUTHORIZE ANTIPSYCHOTIC PRESCRIPTION FOR YOUTH 17 AND YOUNGER

Prescriber Information

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

Mailing Address: _____

_____

Email Address: _____

NPI Number: _____ Tel: _____

Medical Specialty: _____ Fax: _____

Alternate Contact (if applicable):_____

Patient Information

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

Patient MA #: _____ ☐ Male ☐ Female

DOB (mm/dd/yyyy): _____

Height (inches):_____ Date:_____

Weight (pounds):_____ Date:_____

DSM Diagnosis (check all that apply)

☐ ADHD
☐ Autism Spectrum Disorder
☐ Bipolar Disorder
☐ Conduct or Oppositional Defiant Disorder
☐ Disruptive Mood Dysregulation Disorder
☐ Generalized Anxiety Disorder
☐ Intellectual Disability
☐ Major Depressive Disorder
☐ Obsessive Compulsive Disorder
☐ Panic Disorder
☐ Psychotic Disorder – not schizophrenia (specify)_____
☐ Post Traumatic Stress Disorder
☐ Reactive Attachment Disorder
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Substance Related/Addictive Disorder
☐ Tourettes Disorder
☐ Other:_____

Non-DSM Disorder
☐ Traumatic Brain Injury

Target Symptoms (check all that apply)

☐ Aggression
☐ Anxiety
☐ Assault
☐ Delusion
☐ 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:_____
Alk. Phos.:_____
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. ☐ yes ☐ no ☐ referred and appointment pending
Please specify the type of non-pharmacologic/psychosocial services: _____
The patient has been recently treated in an inpatient, emergency or crisis setting. ☐ yes ☐ no date of discharge _____
The patient has a history of known abuse or trauma. ☐ yes ☐ no

CONTINUED ON NEXT PAGE

Patient Name:_____

Antipsychotic for which authorization is being sought (check)

Preferred	Preferred	Preferred	Tier 2 Preferred	Non-Preferred	Non-Preferred
❑ Abilify ®	❑ haloperidol	❑ risperidone	❑ Latuda ®	❑ Abilify ® IM	❑ Olanzapine/Fluoxetine
❑ Abilify Maintena ®	❑ Invega Sustenna®	❑ Risperdal Consta®	❑ olanzapine	❑ Clozapine ODT	❑ Saphris ®
❑ chlorpromazine	❑ perphenazine	❑ thioridazine		❑ Fanapt ®	❑ Seroquel XR ®
❑ clozapine	❑ pimozide	❑ thiothixene		❑ Invega ®	
❑ fluphenazine	❑ quetiapine	❑ trifluoperazine			
		❑ ziprasidone			

Antipsychotic:_____ Strength:_____Regimen:_____ Total Daily Dose:_____

Antipsychotic:_____ Strength:_____Regimen:_____ Total Daily Dose:_____

☐ 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 the reason why this is necessary: _____

_____

_____

Additional Medication Use and History

List the details of trials with other antipsychotics (if any):

Antipsychotic Name	Strength/Frequency	Approximate Dates of Trial	Response/Reason for Discontinuation

List any other psychopharmacologic agents the patient is receiving(if any):

Medication	Strength/Frequency	Approximate Dates of Trial	Indication

Continuation 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 treatment outweigh the risks of treatment.

Prescriber Signature:_____ Date:_____