Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Antipsychotics

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is this an initial request or re-authorization request?

☐ Initial request ☐ Re-authorization request

Q2. What is the product being requested?

☐ Non-preferred Antipsychotic
☐ Antipsychotic for a child under 18 years of age
☐ Other

Q3. If other, please specify:

Q4. Does the member have a history of therapeutic failure of or a contraindication or an intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred Antipsychotics approved or medically accepted for the member's diagnosis or indication?

☐ Yes ☐ No

Q5. Is the requested Antipsychotic prescribed for the treatment of a diagnosis that is consistent with the U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

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Member Name:	Prescriber Name:

☐ Yes ☐ No

Q6. Is the prescribed dose consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q7. Does the member have a current history (within the past 90 days) of being prescribed the same non-preferred Antipsychotic?

☐ Yes ☐ No

Q8. For Opipza (aripiprazole) film, does the member have a contraindication or an intolerance to aripiprazole ODT that would not be expected to occur with Opipza (aripiprazole) film?

☐ Yes ☐ No

Q9. Does the member have a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug?

☐ Yes ☐ No

Q10. Is the member age-appropriate according to U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q11. For an Antipsychotic for a child under the age of 18 years , Does the member have severe symptoms related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses?

☐ Autism spectrum disorder
☐ Intellectual disability
☐ Conduct disorder
☐ Bipolar disorder
☐ Mood disorders with psychotic features
☐ Tic disorder, including Tourette's syndrome
☐ Transient encephalopathy
☐ Schizophrenia and schizophrenia-related disorders

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☐ None of the above

Q12. Is the member prescribed the drug by or in consultation with one of the following?

- ☐ Pediatric neurologist
- ☐ Child and adolescent psychiatrist
- ☐ Child development pediatrician
- ☐ General psychiatrist
- ☐ None of the above

Q13. Is there chart documented evidence of a comprehensive evaluation?

☐ Yes ☐ No

Q14. Is there a documented plan of care that includes non-pharmacologic therapies (e.g., evidence-based behavioral, cognitive, and family based therapies) when indicated according to national treatment guidelines?

☐ Yes ☐ No

Q15. For an Antipsychotic with risk of metabolic changes, is there documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose or hemoglobin A1c, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)?

☐ Yes ☐ No

Q16. Is there documented improvement in target symptoms?

☐ Yes ☐ No

Q17. For an Antipsychotic with risk of metabolic changes, is there documented monitoring of weight or BMI quarterly?

☐ Yes ☐ No

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Member Name:	Prescriber Name:

Q18. Is there documented monitoring of blood pressure, fasting glucose or hemoglobin A1c, fasting lipid panel, and EPS using AIMS after the first three months of therapy and then annually?

☐ Yes ☐ No

Q19. Is there a documented plan for taper/discontinuation of the Antipsychotic or rationale for continued use?

☐ Yes ☐ No

Q20. For the diagnosis Therapeutic duplication, does the member have a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines?

☐ Yes ☐ No

Q21. Additional Information:

_____ _____

Prescriber Signature Date

v2026-06