Jefferson Health Plans

MEDICAID / CHIP
Phone: 866-841-7659 Fax: 866-240-3712

FAX FORM AND CLINICAL DOCUMENTATION

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
☐ 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 866-240-3712

Prescriber Signature:	**Date**: