AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – ASAP: Adult Safety with Antipsychotic Prescribing

Beneficiaries 18 Years of Age and Older

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: _X_365

Clinical Information

For Non-preferred Medications:

1. __ Failed 1 preferred drug? Yes___ No___ List preferred drugs failed: _____
1a. __ Allergic Reaction 1b. __ Drug-to-drug Interaction Please describe reaction: _____
2. __ Previous episode of unacceptable side effect or therapeutic failure. Please provide clinical information: _____
_____
3. __ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provide clinical information: _____
4. __ Age specific indications. Please give patient age and explain: _____
5. __ Unique clinical indication supported by FDA approval or peer reviewed literature.
Please explain and provide a general reference: _____
6. __ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Criteria for ALL medications:

7. What is the beneficiary's Primary Psychiatric diagnosis? ☐ Attention Deficit-Hyperactivity Disorder ☐ Bipolar Disorder
☐ Disruptive Behavior Disorder ☐ Mood Disorder-NOS ☐ Any Pervasive Development Disorder ☐ PTSD
☐ Schizoaffective Disorder ☐ Schizophrenia ☐ Tourette's Syndrome ☐ Other: _____
8. What is the beneficiary's target symptom? ☐ Aggression ☐ Impulsivity ☐ Inattentiveness ☐ Irritability
☐ Mania ☐ Oppositional ☐ Psychosis ☐ Other: _____
9. Has the patient and/or guardian been informed of the potential metabolic adverse effects with this medication and wishes to continue to receive this therapy? Yes___ No___
10. Has the patient and/or guardian been informed of the potential neurologic adverse effects with this medication and wishes to continue to receive this therapy? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406