February 27, 2012

Dear Provider:

**New DPW Prior Authorization Form for Antipsychotic Medications in Children**

The Department of Public Welfare has announced that its Pharmacy Services Call Center has implemented a prior authorization form for requests for antipsychotic medications in children to improve prior authorization response time. The completed form and supporting documentation are to be faxed to the Department of Public Welfare at 1-866-327-0191. For your convenience, the prior authorization form is attached. This form and a list of other available DPW prior authorization forms can be found at: [http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacieservices/priorauthorizationfaxforms/index.htm](http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacieservices/priorauthorizationfaxforms/index.htm). Please note that this form is only for those individuals whose medications are managed by the Department of Public Welfare.

For all other individuals, please refer to their specific Physical Health Managed Care Organization (PH MCO) for prior authorization requirements and available forms. Contact and other information for specific PH MCOs can be found on the Community Care website at [www.ccbh.com/providers/phealthchoices/articles/index.php](http://www.ccbh.com/providers/phealthchoices/articles/index.php). Please feel free to contact Community Care with any additional questions.

Sincerely,

James Schuster, MD, MBA
Chief Medical Officer
Community Care Behavioral Health Organization
**Prior Authorization Form**

To review the prior authorization guidelines for Antipsychotics, please refer to Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter: Antipsychotics at [http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx](http://services.dpw.state.pa.us/olddpw/bulletinsearch.aspx)

*Antipsychotics are subject to quantity limits. To review the quantity limits go to:* [http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacy/services/quantitylimitslist/index.htm](http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/pharmacy/services/quantitylimitslist/index.htm)

### Prior Authorization Request Information

- **For Additional Information:** Coordinator Name: ________________________________ PA#: ____________________
- **Number of Pages for this Recipient’s Request:** ____________________________

### Recipient Information

- **Name:** __________________________
- **Recipient ID#:** ____________________
- **Date of Birth:** ____________________

### Prescriber Information

- **Prescriber Name:** __________________________
- **Specialty:** __________________________
- **NPI#:** ____________________
- **OR MA Provider ID#:** ____________________
- **State License#:** ____________________
- **Prescriber Address:** __________________________
- **Suite #:** ____________________
- **City/State/Zip:** __________________________
- **Phone:** ____________________
- **Fax:** ____________________

### Medical Information

1. **Non-preferred Medications:** □ Abilify □ amitriptyline/perphenazine □ Fanapt □ FazaClo □ Invega □ Latuda □ Saphris □ Symbyax □ thioridazine □ Zyprexa □ Zyprexa Relprevv*
   - **Preferred Medications:** □ chlorpromazine □ clozapine □ fluphenazine □ fluphenazine decanoate injection □ Geodon □ Geodon Injection □ haloperidol □ haloperidol decanoate injection □ haloperidol lactate vial □ Invega Sustenna* □ Navane □ Orap □ perphenazine □ Risperdal Consta* □ risperidone □ Seroquel □ Seroquel XR □ thiothixene □ trifluoperazine
2. **Strength:** ____________________
   - **Directions:** ____________________
   - **Quantity**: ____________________
   - **Refills**: ____________________
3. **Diagnosis:** ____________________
   - **ICD9:** ____________________ *(Required)*

#### Request for a Non-Preferred Agent

1. **Has the recipient tried the preferred medications?** □ Yes *(Provide documentation of dose per day tried)* □ No
2. **Does the recipient have a contraindication/intolerance to the preferred medications?** □ Yes *(Provide documentation)* □ No
3. **For a request for Zyprexa Relprevv, is the recipient being transitioned from oral Zyprexa?** □ Yes □ No
4. **For a request for oral Invega, is the recipient at risk for liver disease?** □ Yes □ No
   - **If yes, please provide the date of the last LFT:** ____________________
   - **Please provide chart documentation of cause for risk and all lab values**
   - **For Abilify, is Abilify being prescribed for adjunctive treatment of depression?** □ Yes *(Provide documentation)* □ No
   - □ Has the recipient tried medications in the following drug classes for treatment of depression?
   - □ SSRIs □ SNRIs □ bupropion *(Provide documentation of dose per day tried)*
   - **Has the recipient tried quetiapine for adjunctive treatment of depression?** □ Yes *(Provide documentation)* □ No

#### Request for a Recipient Less Than 18 Years Of Age

1. **Does the recipient have severe behavioral problems related to psychotic or neuro-developmental disorders?** □ Yes *(Provide documentation)* □ No
2. **Is the requested medication prescribed by, or as a result of a consultation with one of the following Specialists: Child and Adolescent Psychiatrist, Child Development Pediatrician or Pediatric Neurologist?** □ Yes □ No
3. **Has the recipient tried any non-drug therapies?** □ Yes *(Provide documentation)* □ No
4. **Has the recipient had the required baseline and/or follow-up monitoring of the following?**
   - □ Blood Pressure - Date Taken: ____________________
   - □ Fasting Glucose Level - Date Taken: ____________________
   - □ Fasting Lipid Panel - Date Taken: ____________________
   - □ Weight or BMI - Date Taken: ____________________
   - □ Presence of Extrapyramidal Symptoms using the Abnormal Involuntary Movement Scale (AIMS) - Date Taken: ____________________
   - **Please provide chart documentation for all monitoring**

*These injectable Antipsychotics are part of the Specialty Pharmacy Drug Program. Please specify the Specialty pharmacy that the recipient would like to use? □ Accredo Health Group □ Walgreen’s Specialty Pharmacy *(Invega Sustenna and Zyprexa Relprevv are available from Walgreen’s Specialty Pharmacy only.)*

---

**Prescriber Signature:** __________________________

**Confidentiality Notice:** The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.

**Date:** ____________________

**Form Effective 2/13/2012**