Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

ANTIPSYCHOTICS
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Please indicate the diagnosis: Date Diagnosed:_____

□ Bipolar Disorder □ Schizophrenia □ Major Depression with Psychosis

□ Major Depressive Disorder □ Other:_____

Please indicate if the member has been on the following type of therapy:

Please list below all medications tried and failed.

□ Single Antidepressant Therapy

□ Combination Antidepressant Therapy

□ Antidepressant with Augmentation Therapy

FOR ABILIFY REQUESTS ONLY

Is Abilify being used in combination with an SSRI or SNRI? □ Yes □ No

History of Medications Used to Treat Above Condition

□ No other medications have been used to treat this condition

Page 2		
Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

For Children under 12 years of age ONLY

Please Provide CHART DOCUMENTATION for the following:

Relevant rating scale results and the complete DSM Multiaxial diagnosis including the rule-out diagnoses.	Previous medication trials and non-pharmacologic behavioral therapies, including member responses.
Current behavioral difficulties including the frequency and severity and specify the presence of disruptive, aggressive or self-injurious behaviors.	Prior behavioral health assessments/evaluations that support the need for treatment with an antipsychotic medication.

Please provide the following information

Is the member currently under the care of a child/adolescent psychiatrist, pediatric neurologist or child development pediatrician? ☐ Yes ☐ No

If yes, provide physicians name:		Glucose level:	Date:
Weight:	Date:	Height:	Date:
Lipid level:	Date:	BMI:	Date:

List any mental health hospitalization or residential treatment facility during the past 12 months

Facility Name	*Treatment Date(s)*

Please provide any additional information which should be considered in the space below: