



Maryland Medicaid Pharmacy Program  
**Antipsychotic Prior Authorization Form**  
 For Patients 18 Years of Age and Older  
 Phone: 800 932 3918 Fax: 866 440 9345

Patient Information		
Patient Name:	DOB:	MA #

Prescriber Information			
Prescriber Name:	NPI #	Degree:	Specialty:
Treatment site or office address:			
Tel:	Fax:	Email Address:	

DSM Diagnosis (please check all that apply)		
<input type="checkbox"/> ADHD <input type="checkbox"/> Anti-Social or Borderline Personality Disorder <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Conduct or Oppositional Defiant Disorder <input type="checkbox"/> Dementia <input type="checkbox"/> Generalized Anxiety Disorder	<input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Major Depressive Disorder <input type="checkbox"/> Obsessive Compulsive Disorder <input type="checkbox"/> Panic Disorder <input type="checkbox"/> Psychotic Disorder – Not Schizophrenia (Specify): _____	<input type="checkbox"/> PTSD <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Social Phobia <input type="checkbox"/> Tourette's Disorder <input type="checkbox"/> Other Disorder (Specify): _____

Target Symptoms (please check all that apply)			
<input type="checkbox"/> Aggression <input type="checkbox"/> Assault <input type="checkbox"/> Delusion	<input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Insomnia	<input type="checkbox"/> Irritability <input type="checkbox"/> Mania <input type="checkbox"/> Mood instability	<input type="checkbox"/> Self-Injurious Behaviors <input type="checkbox"/> Other(s) (Specify): _____

Antipsychotic for Which Authorization Is Being Sought (please check)				
Tier II Preferred	Non-Preferred			
<input type="checkbox"/> Vraylar® <input type="checkbox"/> Other _____	<input type="checkbox"/> Abilify MyCite® <input type="checkbox"/> Caplyta® <input type="checkbox"/> clozapine ODT <input type="checkbox"/> Fanapt® <input type="checkbox"/> Invega Hafyera®	<input type="checkbox"/> Lybalvi® <input type="checkbox"/> molindone <input type="checkbox"/> Nuplazid® <input type="checkbox"/> olanzapine/fluoxetine <input type="checkbox"/> Perseris®	<input type="checkbox"/> Rexulti® <input type="checkbox"/> Saphris® <input type="checkbox"/> Secuado® <input type="checkbox"/> Versacloz® <input type="checkbox"/> Zyprexa Relprevv®	<input type="checkbox"/> Other _____
Dosage Form:	Strength:	Frequency:	Quantity:	

There is a plan to discontinue or taper an antipsychotic for this patient. Specify Antipsychotic: \_\_\_\_\_

Rationale for Quantity Limit: (If Request is Outside the FDA Maximum for Dose and/or Frequency)	
<input type="checkbox"/> Dose is Being Titrated <input type="checkbox"/> Failed FDA Recommended Regimen (Describe Failed Regimen) <input type="checkbox"/> Other (Explain Rationale)	Description of Rationale:

Is the requested medication a continuation of therapy from an **Inpatient** setting?  Yes - Discharge Date: \_\_\_\_\_  No

Please provide a clinical Rationale for Prescribing Non-Preferred Medication:

**Previous Psychotropic Trials:**  Yes  No **If Yes, please specify below.**

Medication	Strength	Frequency	Duration of Treatment	Is Patient compliant at least 6 days a week?	Reason Discontinued
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

I certify that the benefits of antipsychotic treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Patient's lab/test results and clinical data will be evaluated and monitored.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

**Prescriber Signature** \_\_\_\_\_ **Date** \_\_\_\_\_