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Concurrent IM/PO Antipsychotic Utilization Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at **1-844-512-9004** or Provider Help Desk **1-800-454-3730**

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: Check all boxes that apply.

Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

A prior authorization is required for concurrent long-acting injectable and oral antipsychotic medications after 12 weeks (84 days) of concomitant treatment for members 18 years of age and older. Consideration of concomitant therapy beyond 12 weeks (84 days) will require documentation of medical necessity. Prior authorization is required for all nonpreferred antipsychotics as indicated on the Iowa Medicaid *Preferred Drug List* beginning the first day of therapy. Payment for nonpreferred antipsychotics will be considered only for cases in which there is documentation of previous trials and therapy failures with a preferred agent.

Injectable antipsychotic medication:

Drug name & strength:_____Dosing instructions:_____Quantity:_____Days' supply: _____

Oral antipsychotic medication:

Drug name & strength:_____Dosing instructions:_____Quantity:_____Days' supply: _

Medical necessity for concurrent IM/PO antipsychotic use beyond 12 weeks (84 days): _____

_____

Proposed drug tapering schedule: _____

_____

Reason for use of no preferred drug requiring prior approval: _____

_____

Other medical conditions to consider: _____

_____

Attach lab results and other documentation as necessary.