Amerigroup

Medicaid

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Antipsychotics
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-474-3341.

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.)

Patient's age: _____

Patient's age: _____

□ Yes □ No Does the patient have a diagnosis of insomnia in the last 365 days?

□ Yes □ No Does the patient have a diagnosis of major depressive disorder in the last 365 days?

□ Yes □ No Does the patient have one of the following diagnoses in the last 730 days (please indicate)?

- □ Agitation Associated with Dementia Due to Alzheimer's Disease
- □ Autistic Disorder
- □ Bipolar Disorder, Current Episode Hypomanic
- □ Bipolar Disorder, Current Episode Manic Without Psychotic Features
- □ Bipolar Disorder, Current Episode Mixed
- □ Bipolar Disorder, Unspecified
- □ Bipolar I Disorder, Single Manic Episode

□ Bipolar I Disorder, Most Recent Episode (or current) Manic
□ Bipolar I Disorder, Most Recent Episode (or current) Depressed
□ Bipolar I Disorder, Most Recent Episode (or current) Mixed
□ Bipolar I Disorder, Most Recent Episode (or current) Unspecified
□ Bipolar II Disorder
□ Childhood Disintegrative Disorder
□ Conduct Disorder, Childhood-Onset Type
□ Conduct Disorder, Adolescent-Onset Type
□ Conduct Disorder, Unspecified
□ Delusional Disorders
□ Intermittent Explosive Disorder
□ Oppositional Defiant Disorder
□ Other Bipolar Disorders
□ Other Persistent Mood Disorder
□ Other Pervasive Developmental Disorder
□ Other Specified Episodic Mood Disorder
□ Other Specified Paranoid States
□ Other Specified Pervasive Developmental Disorder
□ Paraphrenia
□ Pervasive Developmental Disorder, Unspecified
□ Pervasive Developmental Disorders
□ Schizophrenia
□ Schizophrenic Disorders
□ Shared Psychotic Disorder
□ Tourette's Disorder
□ Unspecified Episodic Mood Disorder
□ Unspecified Mental Disorder Due to Known Physiological Condition
□ Unspecified Mood Disorder
□ Unspecified Paranoid State
□ Unspecified Pervasive Developmental Disorder
□ Unspecified Psychosis
□ Unspecified Psychosis Not Due to a Substance or Known Physiological Condition

□ Yes □ No Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.

□ Yes □ No Patient has a documented allergy or contraindication to preferred agents in this class.

□ Yes □ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions.

For the Texas Medicaid *Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at **txvendordrug.com/formulary/formulary-search**.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.