Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Clozapine Under 18 Years of Age
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information				
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female		Height:
Member ID:	City:	State:		Weight:
Prescribing Provider Information				
Provider Name (first & last):	Specialty:	NPI#		DEA#
Office Address:	City:	State:		Zip Code:
Office Contact:	Office Phone	Office Fax:		
Dispensing Pharmacy Information				
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:		
Turn-Around Time				
☐ Standard – (24 hours)	☐ Urgent – Waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function; you are requesting an expedited decision. Signature: ______________________________			

Requested Medication Information				
Are there any contraindications to formulary medications? (If yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy
For continuation of therapy only:	There is improvement in psychosis	☐ Yes	☐ No	
	There was continued follow-up of labs per protocol	☐ Yes	☐ No	
	There is documentation of adherence and tolerability	☐ Yes	☐ No	
What medication(s) were tried and failed for this diagnosis?	Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No			
What is the diagnosis ICD-10 Code?	Diagnosis:			
Directions for Use:				

Quantity:	Day Supply:	Duration of Therapy/Use:	Strength:	Dosage Form:

Clinical Information	
Does member have a clear diagnosis of schizophrenia or schizoaffective disorder? Yes No	Was diagnosis determined after a detailed psychiatric evaluation by a child and adolescent Behavioral Health Medical Provider? Yes No

Is Behavioral Health Medical Provider enrolled in the REMS program?	☐ Yes	☐ No

Did evaluation include a full family, psychiatric and medical history? Yes No	Did evaluation include a full medical and psychiatric review of systems and complete MSE? Yes No

Is psychosis better accounted for by other diagnoses, including severe PTSD, substance induced psychosis, bipolar disorder, neurologic condition, or hypnogogic hallucinations, and is persistent in absence of stressors?	☐ Yes	☐ No

Is the targeted treatment goal for psychosis ONLY?	☐Yes	☐No	Was there a trial, and an inadequate response with another formulary antipsychotic at the maximum tolerated dose?	☐ Yes	☐ No
Did BHMP evaluate and determine medication non-adherence was not reason for inadequate response to maximum tolerated dose?	☐ Yes	☐ No	Did BHMP rule out non-response due to unrecognized or under-treated co-morbid disorder?	☐ Yes	☐ No

Was an informed consent and youth assent obtained prior to initiation?	☐ Yes	☐ No	☐ N/A	Were baseline labs completed prior to start of medication?	☐ Yes	☐ No

If youth is inpatient, did an Acute or BHIF consultation with outpatient BHMP and CFT occur?	☐ Yes	☐ No	☐ N/A

Was clozapine started during recent hospitalization?	☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: ______________________________ **Date:** ________________

<u>Please note: Incomplete forms or forms without the chart notes will be returned</u>

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request