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

Concomitant Antipsychotic Treatment
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				
☐ aripiprazole	☐ aripiprazole	☐ aripiprazole	☐ aripiprazole	☐ aripiprazole
☐ loxapine	☐ loxapine	☐ loxapine	☐ loxapine	☐ loxapine
☐ perphenazine	☐ perphenazine	☐ perphenazine	☐ perphenazine	☐ perphenazine
☐ Other (please specify):				
Are there any contraindications to formulary medications? (If yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of therapy
Medications were started during recent hospitalization (circle one): ☐ Yes ☐ No	Medication request is NOT for an FDA approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No			
What is the diagnosis ICD-10 Code?	Diagnosis:			
What medication(s) were tried and failed for this diagnosis?				
Directions for Use:				
Quantity:	Day Supply:	Duration of Therapy/Use:	Strength:	Dosage Form:
Clinical Information				
Is the cross-tapering due to transitioning from one medication to another?	☐ Yes	☐ No	☐ N/A	
For refractory schizophrenia	Is there evidence of adequate trials with 3 individual antidepressants listed on the	☐ Yes	☐ No	

spectrum disorder:	AHCCCS Behavioral Health Drug List, from 2 different therapeutic classes?					
Were these trials for a period of 4-6 weeks at maximum tolerated doses?					☐ Yes	☐ No
Failures were due to ONE of the following:	☐ Inadequate response at maximum tolerated doses		☐ Adverse reaction(s)		☐ Break through symptoms	
For refractory bipolar disorder w/psychosis and/or severe symptoms:	Were there trials of 4 evidence-based treatment options dependent upon episode type?	☐ Yes	☐ No	Were these trials for a period of 4-6 weeks at maximum tolerated doses?	☐ Yes	☐ No
Failures were due to ONE of the following:	☐ Inadequate response at maximum tolerated doses		☐ Adverse reaction(s)	☐ Break through symptoms		
Are there TWO different prescribers prescribing that the coordination of care has occurred?					☐ Yes	☐ No
Is there documentation that adherence to treatment regimen was not a contributing factor to inadequate response to medication trials?					☐ 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:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

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