



Fax completed prior authorization request form to 855-247-3677 (Integrated population) or 855-246-7736 (SMI Non- Title population) 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/rbha-forproviders/pharmacy

Long Acting Antipsychotic Injectables 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:		Height:	
		<input type="checkbox"/> Male	<input type="checkbox"/> Female		
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 for Review					
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> 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					
<input type="checkbox"/> ABILIFY MAINTENA	<input type="checkbox"/> ARISTADA	<input type="checkbox"/> ARISTADA INITIO		<input type="checkbox"/> fluphenazine decanoate	
<input type="checkbox"/> RISPERDAL CONSTA	<input type="checkbox"/> INVEGA TRINZA	<input type="checkbox"/> INVEGA SUSTENNA		<input type="checkbox"/> haloperidol decanoate	
Medication was started during recent hospitalization (circle one): Yes No		Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No			
Are there any contraindications to formulary medications? (If yes, please specify):		<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request	<input type="checkbox"/> Continuation of therapy
Was the long acting antipsychotic started during recent hospitalization? (circle one): Yes No		Was the recommended oral dosage received (per FDA approved labeling) to confirm tolerability and efficacy? Yes No			
What is the diagnosis ICD-10 Code?		Diagnosis:			
What medication(s) were tried and failed for this diagnosis?					
Directions for Use:		Strength:		Dosage Form:	
		Quantity:	Day Supply:	Duration of Therapy/Use:	
Clinical Information					
Was there non-adherence to oral antipsychotic medications; and this places member at risk for poor outcomes?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will member receive concurrent oral antipsychotics after the initial overlap period?				<input type="checkbox"/> Yes	<input type="checkbox"/> No
Provider agrees to supports baseline and routine monitoring of ALL the following:				<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Weight, BMI, or waist circumference	<input type="checkbox"/> BP	<input type="checkbox"/> Fasting Lipid Panel	<input type="checkbox"/> Fasting Glucose	<input type="checkbox"/> Tardive Dyskinesia using AIMS or DISCUS	
Is member taking a Cytochrome P450 3A4 (CYP3A4) inducer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was a metabolic screening completed within the last 60 days?		<input type="checkbox"/> Yes <input type="checkbox"/> 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 800-564-5465 to check the status of a request