carolina complete health

Pharmacy PA Request for ASAP: Adult Safety with Antipsychotic Prescribing
Beneficiaries 18 Years of Age and Older

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (In days): ☒ 365 days

Clinical Information

For Non-preferred Medications:

1. ☐ Failed 1 preferred drug? ☐ **Yes** ☐ **No**
   List preferred drugs failed: _____
   1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____
   _____
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information: _____
3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____
   _____
4. ☐ Age specific indications. Please give patient age and explain: _____
   _____
5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____ - _____
   _____

Criteria for All medications:

7. What is the beneficiary's Primary Psychiatric diagnosis? ☐ Attention Deficit-Hyperactivity Disorder ☐ Bipolar Disorder ☐ Disruptive Behavior Disorder ☐ Mood Disorder-NOS ☐ Any Pervasive Development Disorder ☐ PTSD ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Tourette's Syndrome ☐ Other: _____
8. What is the beneficiary's target symptom? ☐ Aggression ☐ Impulsivity ☐ Inattentiveness ☐ Irritability ☐ Mania ☐ Oppositional ☐ Psychosis ☐ Other: _____
9. Has the patient and/or guardian been informed of the potential metabolic adverse effects with this medication and wishes to continue to receive this therapy? ☐ **Yes** ☐ **No**
10. Has the patient and/or guardian been informed of the potential neurologic adverse effects with this medication and wishes to continue to receive this therapy? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/

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