UnitedHealthcare Community Plan

Antipsychotics - Pennsylvania
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____

_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS	
□ Yes □ No	**Does the patient have a history of therapeutic failure, contraindication, or intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred antipsychotics?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a current history (within the past 90 days) of being prescribed the same requested medication?**
INVEGA (PALIPERIDONE ER)	
□ Yes □ No	**Does the patient have active liver disease with elevated liver function tests (LFTs) or is at risk for active liver disease?**
LESS THAN 18 YEARS OF AGE	
□ Yes □ No	**Does the patient have severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses?** *(If yes, check which applies)* □ Autism spectrum disorder □ Bipolar disease □ Conduct disorder □ Intellectual disability □ Schizophrenia □ Tic disorder, including Tourette's syndrome □ Transient encephalopathy
□ Yes □ No	**Is the requested medication being prescribed by or in consultation with one of the following?** *(If yes, check which applies)* □ Child and adolescent psychiatrist □ General psychiatrist □ Child development pediatrician □ Pediatric neurologist
□ Yes □ No	**Does the patient have chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies such as, but not limited to, evidence-based behavioral, cognitive, and family based therapies?**
□ Yes □ No	**Does the patient have documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)?**
CONTINUATION OF THERAPY – LESS THAN 18 YEARS OF AGE	
□ Yes □ No	**Does the patient have documented improvement in target symptoms?**
□ Yes □ No	**Does the patient have documented monitoring of weight or body mass index (BMI) quarterly?**
□ Yes □ No	**Does the patient have documented monitoring of blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS) after the first 3 months of therapy and then annually?**
□ Yes □ No	**Is there a documented plan for taper/discontinuation of the antipsychotic or rationale for continued use?**
THERAPEUTIC DUPLICATION	
□ Yes □ No	**For an <u>atypical</u> antipsychotic, is the patient being titrated to, or tapered from, another atypical antipsychotic?**
□ Yes □ No	**For a <u>typical</u> antipsychotic, is the patient being titrated to, or tapered from, another typical antipsychotic?**
□ Yes □ No	**Does the prescriber have a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines?**

Provider Signature: _____ **Date:** _____