



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Atypical Antipsychotics

Phone: 800-728-7947

Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	Prescriber Name:	
Member/Subscriber Number:	Supervising Physician:	
Date of Birth:	Fax:	Phone:
Group Number:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What drug is being requested? <input type="checkbox"/> Fanapt <input type="checkbox"/> Latuda <input type="checkbox"/> Saphris <input type="checkbox"/> Vraylar
Q2. What are the quantity and days supply requested?
Q3. What diagnosis is the drug being prescribed for? <input type="checkbox"/> Bipolar Disorder I <input type="checkbox"/> Schizoaffective Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other
Q4. Please provide ICD code(s) for diagnosis.
Q5. Is the patient a new start to therapy? If no, please provide start date.



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Yes

No

Q6. Did the patient have failure of an adequate trial of, contraindication, or intolerance to any of the following?

- aripiprazole
- clozapine
- olanzapine
- paliperidone
- quetiapine
- risperidone
- ziprasidone
- None of the above

Q7. Additional Comments

Prescriber Signature

Date

Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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