SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Atypical Antipsychotics (Non-Preferred)

Drug Requested: (select one from below)

❑ **Abilify® tab/IM inj** (aripiprazole)	❑ **Abilify Mycite® tab/IM inj*** ***(Refer for Abilify Mycite PA form)**	❑ **aripiprazole ODT, solution**
❑ **asenapine** (generic Saphris®)	❑ **Bysanti®** (milsaperidone)	❑ **Caplyta™**
❑ **clozapine ODT**	❑ **Clozaril®** (clozapine)	❑ **Cobenfy™**
❑ **Cobenfy™ Starter pk**	❑ **Fanapt®** (iloperidone) **tab & titration pk**	❑ **FazaClo®** (clozapine)
❑ **Geodon® tab/IM inj** (ziprasidone HCl)	❑ **Invega®**(paliperidone)	❑ **Latuda®**(lurasidone)
❑ **Lybalvi®** (olanzapine/ samidorphan)	❑ **Nuplazid®** (Pimavanserin) **tab/cap (QL) (AG)**	❑ **olanzapine/ fluoxetine**
❑ **Opipza™**	❑ **quetiapine ER (AG) - only authorized generic non- preferred)**	❑ **Rexulti®**(brexipirazole)
❑ **Risperdal® ODT/soln/tab** (risperidone)	❑ **Saphris®**(asenapine)	❑ **Secuado® Patch** (asenapine)
❑ **Seroquel IR®** (quetiapine)	❑ **Seroquel XR®** (quetiapine)	❑ **Versacloz™** (clozapine, USP)
❑ **Zyprexa®** (olanzapine tab/IM/Zydis)		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Nuplazid™ is indicated for the treatment of hallucinations and delusions associated with Parkinson's disease psychosis. Member must have tried and failed at least two (2) of the Preferred drugs.

- **If diagnosis is any type of depressive disorder, please list current antidepressant therapy:**

  _____

  _____

  _____

  _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Patient has tried and failed at least two (2) of the following PREFERRED drugs:**

❑ aripiprazole tab	❑ clozapine tab	❑ lurasidone
❑ olanzapine ODT, tab, IM	❑ quetiapine tab/ quetiapine ER	❑ risperidone ODT/soln/tab
❑ Vraylar™ (**Refer to PA form for Major Depressive Disorder diagnosis**)	❑ ziprasidone capsule/vial	❑ paliperidone ER tab

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

REVISED/REFORMATTED/UPDATED: ~~3/21/2018; 8/16/2018; 6/18/2019; 6/22/2022; 7/13/2022; 6/23/2023;07/10/23; 11/8/2023; 6/19/2025, 2/23/2026, 3/6/2026;~~ **6/4/2026**