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 information provided is not complete, correct, or legible, authorization may 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®)
❑ **Caplyta™**	❑ **clozapine ODT**	❑ **Clozaril®** (clozapine)	❑ **Fanapt®** (iloperidone) **tab & titration pk**
❑ **FazaClo®** (clozapine)	❑ **Geodon® tab/IM inj** (ziprasidone HCl)	❑ **Invega®** (paliperidone) ❑ **paliperidone ER**	❑ **Latuda®** (lurasidone)
❑ **Lybalvi®** (olanzapine/ samidorphan	❑ **Nuplazid®** (Pimavanserin) **tab/cap (QL) (AG)**	❑ **Quetiapine ER** (AG) - only authorized generic non- preferred	❑ **Rexulti®** (brexipirazole)
❑ **Risperdal® ODT/soln/tab** (risperidone)	❑ **Saphris®** (asenapine)	❑ **Secuado® Patch** (asenapine)	❑ **Seroquel®** (quetiapine)
❑ **Seroquel XR®** (quetiapine)	❑ **Symbyax®** olanzapine/fluoxetine	❑ **Versacloz™** (clozapine, USP)	❑ **Zyprexa®** (olanzapine tab/IM inj/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:** _____

DEA OR NPI #: _____

(Continued on next page)

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

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™	❑ ziprasidone capsule	

*****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.****