

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)

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

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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 #: _____

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:

<input type="checkbox"/> aripiprazole tab	<input type="checkbox"/> clozapine tab	<input type="checkbox"/> lurasidone
<input type="checkbox"/> olanzapine ODT, tab, IM	<input type="checkbox"/> quetiapine tab/ quetiapine ER	<input type="checkbox"/> risperidone ODT/soln/tab
<input type="checkbox"/> Vraylar™ (Refer to PA form for Major Depressive Disorder diagnosis)	<input type="checkbox"/> ziprasidone capsule/vial	<input type="checkbox"/> 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.