

Fax completed prior authorization request form to 844-802-1412 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. Incomplete forms or forms without the chart notes will be returned

Aetna Better Health®

Pharmacy Coverage Guidelines are available at https://www.aetnabetterhealth.com/Illinois-medicaid

Atypical Antipsychotics Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

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Member Information		licai i	esung red	evant	to request snowin	g meaicai ji	ıstını	cationare	requii	rea to	supportalagn		
Member Name (first & last):			Date of B			Geno	der:		Height:				
					☐ Male ☐ Fe			male					
Member ID:			City:		State:				Weight:				
Prescribing Provide	er Information												
Provider Name (first	Specialty	/ :		NPI#			DEA#						
Office Address:		City:			State:			Zip Co	Code:				
Office Contact:		Offic	ce Phone	Office Fax									
Dispensing Pharma	cy Information												
Pharmacy Name:				Phar	rmacy Phone:	Pharmacy			Fax:				
Requested Medicat	ion Information						,						
□ Clozapine ODT				ne	□ quetiapine El	R 🗆 Saphris 🗆 La			atuda 🗆 Fa] Fanapt		
□ Vraylar	☐ Secuado												
Are there any contro (If yes, please speci		□ Yes		request									
☐ Continuation of	ement in target symptoms												
require docume	eatm	nent plan containing rationale for continued use or plan for D/C											
(check that apply):				embe	ber weight						oreen		
Is member new to Plan AND/OR using samples for a NON-PREFERRED antipsychotic? (circle one): Yes No													
Is request for more than ONE antipsychotic due to needed					, ,								
60-day cross titration? (circle one): Yes No					recent HOSPITALIZATION? (circle one): Yes No								
Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one):													
Diagnosis ICD-10 Code?					Diagnosis:								
Directions for Use:					Strength:					Dosage Form:			
					Quantity:	Day Supp	Day Supply:			Duration of			
									Therapy/Use:				
Turn-Around Time f	or Review												
					ing 24 hours for a st in maximum function				-				
Signature:								- "-					
Clinical Information													
☐ Children 6-17 \													

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Was blood glucose OR hemoglobin A1C			3 🗆 I		Was cholesterol testing OR LDL-C completed					Yes		No
completed at baseline AND then yearly?					baseline AND then yearly?				_	V		NI-
Was weight complete	⊔ Yes	Yes No Was screening for m							Yes		No	
then yearly? with antipsychotic therapy completed? NEW STARTS ONLY:												
Are residual symptoms continuing despite use non-pharmacologic therapies such as behavioral, cognitive AND										Yes		No
family based therapie												
	Additional Criteria Based on Indication											
☐ Bipolar Disorder	☐ Schizophrenia	□ Ps	sychon	notor A	gitation A	Associa	ted	☐ Chronic Tic Disorder	□T	ourett	e's	
•	•		□ Psychomotor Agitation Associated □ Chronic Tic Disorder with Autism Spectrum Disorder						Syndrome			
Is requested antipsycl	Yes	□ No	If no	, was the	re inade	quate r	response OR intolerable		Yes		No	
PREFERRED agent?							•	RED agents?				
☐ Major Depressive D	isorder								•			
Was there inadequate response OR intolerable side effect to \square Yes \square No Did medication regimen									Yes		No	
THREE different medic	cation regimens for de	epress	on for	at				e antidepressant				
least 4 weeks?			monotherapy?					1				
		ssant a	ugmer	ntation v	vith SSRI	ORSNE	RI + bup	propion OR Lithium OR		Yes		No
buspirone OR liothyro			Vas	□ Na	\\/aa +h			- Hannaman OD		Vaa		Na
Is requested antipsycl agent?	HOLIC PREFERRED		Yes	□ No				e response OR t to TWO PREFERRED		Yes		No
agent						al antips						
Clinical Information -	- NON-PREFERRED A	AGENT	S		atypio	at all tape	, y 0.10 a c	50.				
☐ Adults 18 Years of												
Was blood glucose Of		Тп	Yes	□ No	Was c	holester	ol taetii	ng OR LDL-C completed		Yes		No
_	•		163	□ INO				=		163		140
	eted at baseline AND then yearly? at baseline AND then yearly? at baseline AND then yearly?									Yes		No
then yearly?	as weight completed at baseline AND								163		140	
then yearty:					compl		παπαρ	sycholic therapy				
Additional Critoria B	seed on Indication				Compt	eteu:						
Additional Criteria Based on Indication												
□ Bipolar Disorder □ Schizophrenia												
Was there inadequate response OR intolerable side effect to TWO PREFERRED atypical antipsychotics?												
-		able si	de erre	Ct to TW	OPREFE	ERRED	пурісаі	anupsycholics:		Yes	Ц	No
☐ Major Depressive	Disorder		de erre	Ct to TV						Yes	Ш	No
☐ Major Depressive Was there inadequate	Disorder e response OR intolera		□ Ye		lo Did	l medica	ation re	gimen include		Yes		No
☐ Major Depressive Was there inadequate side effect to THREE c	Disorder response OR intoleraliferent medication				lo Did	l medica	ation re					
☐ Major Depressive Was there inadequate side effect to THREE cregimens for depressi	Disorder response OR intoleraliferent medication				lo Did	l medica	ation re	gimen include				
☐ Major Depressive Was there inadequate side effect to THREE or regimens for depressive weeks?	Disorder e response OR intolera different medication on for at least FOUR	able	□ Ye	s 🗆 N	lo Did	l medica idepres	ation res	gimen include onotherapy?		Yes		No
☐ Major Depressive Was there inadequate side effect to THREE c regimens for depressi weeks? Did medication regime	Disorder response OR intolera different medication on for at least FOUR en include antidepres	able		s 🗆 N	lo Did	l medica idepres	ation resant mo	gimen include onotherapy? uate response OR				
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Signature affirms that information given on this form is true and accurate and reflects office notes.							
Prescribing Provider's Signature:	Date:						
	5 00.5.						

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required. Standard turnaround time is 24 hours. You can call 866-329-4701 to check the status of a request.

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