



Fax completed prior authorization request form to 877-309-8077 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 www.aetnabetterhealth.com/pennsylvania/providers/pharmacy

Atypical Antipsychotics Pharmacy Prior Authorization Request Form

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

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information						
Member Name (first & last):	Date of Birth:	Gender:		Height:		
		<input type="checkbox"/> Male	<input type="checkbox"/> Female			
Member ID:	City:	State:		Weight:		
Prescribing Provider Information						
Provider Name (first & last):	Specialty:	NPI#		DEA#		
Office Address:	City:	State:		Zip Code:		
Office Contact:		Office Phone		Office Fax:		
Dispensing Pharmacy Information						
Pharmacy Name:		Pharmacy Phone:		Pharmacy Fax:		
Requested Medication Information						
Preferred Agents:	<input type="checkbox"/> aripiprazole tablets	<input type="checkbox"/> clozapine	<input type="checkbox"/> olanzapine	<input type="checkbox"/> ziprasidone	<input type="checkbox"/> quetiapine	<input type="checkbox"/> risperidone
Non-Preferred Agents:	<input type="checkbox"/> Fanapt	<input type="checkbox"/> Saphris	<input type="checkbox"/> Latuda	<input type="checkbox"/> paliperidone ER		<input type="checkbox"/> quetiapine ER
	<input type="checkbox"/> Rexulti	<input type="checkbox"/> Secuado	<input type="checkbox"/> Vraylar	<input type="checkbox"/> Other, please specify:		
Are there any contraindications to medications? (If yes, please specify):				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> New request
Continuation of therapy requests require documentation of following (check that apply):		<input type="checkbox"/> Improvement in target symptoms				
		<input type="checkbox"/> Treatment plan containing rationale for continued use or plan for D/C				
		<input type="checkbox"/> Member weight				
		<input type="checkbox"/> Screen for movement disorders				
		<input type="checkbox"/> Metabolic screen				
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):			Did member start on NON-PREFERRED antipsychotic during recent HOSPITALIZATION? (circle one):			
Yes No			Yes No			
Medication request is NOT for an FDA-approved, or compendia-supported diagnosis (circle one):						
Yes No						
What is the diagnosis ICD-10 Code?			Diagnosis:			
Directions for Use:			Strength:		Dosage Form:	
			Quantity:	Day Supply:	Duration of Therapy/Use:	
Turn-Around Time for Review						
<input type="checkbox"/> Standard – (24 hours)		<input type="checkbox"/> Urgent – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision.				

Signature: _____

Clinical Information

Children 6-17 Years of Age

Is blood glucose OR hemoglobin A1c completed at baseline, and then yearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has cholesterol testing OR LDL-C been completed at baseline, and then yearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was weight completed at baseline, and then yearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was screening for movement disorders associated with antipsychotic therapy completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> NEW STARTS ONLY: Are residual symptoms continuing despite use non-pharmacologic therapies such as behavioral, cognitive and family based therapies?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Additional Criteria Based on Indication

<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Psychomotor Agitation Associated with Autism Spectrum Disorder	<input type="checkbox"/> Chronic Tic Disorder	<input type="checkbox"/> Tourette's Syndrome
Is requested antipsychotic a PREFERRED agent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there inadequate response, or intolerable side effect to TWO PREFERRED agents?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Major Depressive Disorder				
Was there inadequate response OR intolerable side effect to THREE different medication regimens for depression for at least 4 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did medication regimen include an antidepressant monotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did medication regimen include an antidepressant augmentation with an SSRI OR SNRI + bupropion OR Lithium OR buspirone OR liothyronine?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the requested antipsychotic a PREFERRED agent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there inadequate response OR intolerable side effect to TWO PREFERRED atypical antipsychotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Clinical Information – NON-PREFERRED AGENTS

Adults 18 Years of Age or Older

Was blood glucose OR hemoglobin A1c completed at baseline, and then yearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was cholesterol testing OR LDL-C completed at baseline, and then yearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was weight completed at baseline, and then yearly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was screening for movement disorders associated with antipsychotic therapy completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional Criteria Based on Indication

<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Schizophrenia			
Was there inadequate response OR intolerable side effect to TWO PREFERRED atypical antipsychotics?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Major Depressive Disorder				
Was there inadequate response, or intolerable side effect to THREE different medication regimens for depression for at least FOUR weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Did medication regimen include antidepressant monotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Did medication regimen include antidepressant augmentation with SSRI OR SNRI + bupropion OR Lithium OR buspirone OR liothyronine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there inadequate response OR intolerable side effect to TWO PREFERRED atypical antipsychotics?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Children Age 5 and Under				
Are residual symptoms continuing despite use of NON-PHARMACOLOGIC THERAPIES such as behavioral, cognitive AND family based therapies?			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was baseline AND routine monitoring of weight and BMI OR waist circumference completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was baseline AND routine monitoring of BP, fasting glucose AND fasting lipid panel completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was baseline and routine monitoring of tardive dyskinesia using AIMS or DISCUS completed?			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Large empty rectangular box for chart notes.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

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 to check the status of a request.
Pennsylvania CHIP:1-800-822-2447.