

ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM

(form effective 1/5/2026)



Fax to PerformRxSM at **1-855-851-4058**, or to speak to a representative call **1-888-674-8720**.

PRIOR AUTHORIZATION REQUEST INFORMATION				
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total pages:	Office contact/phone:	LTC facility contact/phone:

PATIENT INFORMATION			
Patient name:		Patient ID#:	DOB:
Street address:		Apt #:	City/state/zip:

PRESCRIBER INFORMATION			
Prescriber name:			
Specialty:		NPI:	State license #:
Street address:		Suite #:	City/state/zip:
Phone:		Fax:	

MEDICATION REQUESTED			
Preferred Agents			
Non-Injectable			
<input type="checkbox"/> Aripiprazole Tablet	<input type="checkbox"/> Haloperidol Tablet	<input type="checkbox"/> Olanzapine Tablet	<input type="checkbox"/> Risperidone Solution
<input type="checkbox"/> Clozapine Tablet	<input type="checkbox"/> Haloperidol Lactate Oral Concentrate Solution	<input type="checkbox"/> Paliperidone ER Tablet	<input type="checkbox"/> Risperidone Tablet
<input type="checkbox"/> Equetro (carbamazepine) Capsule	<input type="checkbox"/> Loxapine Capsule	<input type="checkbox"/> Perphenazine Tablet	<input type="checkbox"/> Trifluoperazine Tablet
<input type="checkbox"/> Fluphenazine Oral Concentrate Solution	<input type="checkbox"/> Lurasidone Tablet	<input type="checkbox"/> Quetiapine Tablet	<input type="checkbox"/> Ziprasidone Capsule
<input type="checkbox"/> Fluphenazine Tablet		<input type="checkbox"/> Quetiapine ER Tablet	
Injectable			
<input type="checkbox"/> Abilify Asimtufii (aripiprazole)	<input type="checkbox"/> Fluphenazine Decanoate Vial	<input type="checkbox"/> Haloperidol Lactate Vial	<input type="checkbox"/> Perseris ER (risperidone)
<input type="checkbox"/> Abilify Maintena (aripiprazole)	<input type="checkbox"/> Haloperidol Decanoate Ampule	<input type="checkbox"/> Invega Hafyera (paliperidone)	<input type="checkbox"/> Risperdal Consta (risperidone)
<input type="checkbox"/> Aristada ER (aripiprazole lauroxil)	<input type="checkbox"/> Haloperidol Decanoate Vial	<input type="checkbox"/> Invega Sustenna (paliperidone)	<input type="checkbox"/> Risperidone ER Vial
<input type="checkbox"/> Aristada Initio (aripiprazole lauroxil)	<input type="checkbox"/> Haloperidol Lactate Syringe	<input type="checkbox"/> Invega Trinza (paliperidone)	<input type="checkbox"/> Uzedy ER (risperidone)
Strength:	Dosage form:	Directions:	
Diagnosis:			

Non-Preferred Agents			
Non-Injectable			
<input type="checkbox"/> Abilify (aripiprazole) Tablet	<input type="checkbox"/> Cobenfy (xanomeline-trospium) Capsule	<input type="checkbox"/> Olanzapine ODT	<input type="checkbox"/> Secuado (asenapine) Patch
<input type="checkbox"/> Adasuve (loxapine) Inhalation Powder	<input type="checkbox"/> Fanapt (iloperidone) Tablet	<input type="checkbox"/> Olanzapine-Fluoxetine Capsule	<input type="checkbox"/> Seroquel (quetiapine) Tablet
<input type="checkbox"/> Aripiprazole ODT	<input type="checkbox"/> Fluphenazine Elixir	<input type="checkbox"/> Opipza (aripiprazole) Film	<input type="checkbox"/> Seroquel XR (quetiapine) Tablet
<input type="checkbox"/> Aripiprazole Solution	<input type="checkbox"/> Geodon (ziprasidone) Capsule	<input type="checkbox"/> Perphenazine-Amitriptyline Tablet	<input type="checkbox"/> Thioridazine Tablet
<input type="checkbox"/> Asenapine SL Tablet	<input type="checkbox"/> Invega ER (paliperidone) Tablet	<input type="checkbox"/> Pimozide Tablet	<input type="checkbox"/> Thiothixene Capsule
<input type="checkbox"/> Caplyta (lumateperone) Capsule	<input type="checkbox"/> Latuda (lurasidone) Tablet	<input type="checkbox"/> Rexulti (brexipiprazole) Tablet	<input type="checkbox"/> Versacloz (clozapine) Suspension
<input type="checkbox"/> Chlorpromazine Concentrate Solution	<input type="checkbox"/> Lybalvi (olanzapine/samidorphan) Tablet	<input type="checkbox"/> Risperdal (risperidone) Solution	<input type="checkbox"/> Vraylar (cariprazine) Capsule
<input type="checkbox"/> Chlorpromazine Tablet	<input type="checkbox"/> Molindone Tablet	<input type="checkbox"/> Risperdal (risperidone) Tablet	<input type="checkbox"/> Zyprexa (olanzapine) Tablet
<input type="checkbox"/> Clozapine ODT	<input type="checkbox"/> Nuplazid (pimavanserin) Capsule	<input type="checkbox"/> Risperidone ODT	<input type="checkbox"/> Zyprexa (olanzapine) Zydis
<input type="checkbox"/> Clozaril (clozapine) Tablet	<input type="checkbox"/> Nuplazid (pimavanserin) Tablet	<input type="checkbox"/> Saphris SL (asenapine) Tablet	
Injectable			
<input type="checkbox"/> Chlorpromazine Ampule	<input type="checkbox"/> Geodon (ziprasidone) Vial	<input type="checkbox"/> Olanzapine Vial	<input type="checkbox"/> Zyprexa Relprevv (olanzapine)
<input type="checkbox"/> Chlorpromazine Vial	<input type="checkbox"/> Haldol Decanoate (haloperidol) Ampule	<input type="checkbox"/> Ziprasidone Vial	<input type="checkbox"/> Zyprexa (olanzapine) Vial
<input type="checkbox"/> Fluphenazine HCl Vial			
Strength:	Dosage form:	Directions:	
Diagnosis:			

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):	
Deliver to: <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
<input type="checkbox"/> I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

REQUEST FOR A NON-PREFERRED AGENT	
1. Has the patient taken the requested non-preferred antipsychotic in the past 90 days?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No
2. Has the patient tried and failed the preferred medications (listed above)?	<input type="checkbox"/> Yes – List medications tried: _____ <input type="checkbox"/> No
3. Does the patient have a contraindication or intolerance to the preferred medications?	<input type="checkbox"/> Yes – <i>Submit documentation of contraindication/intolerance.</i> <input type="checkbox"/> No
4. For request of Opipza (aripiprazole) film: Does the patient have a contraindication or intolerance to aripiprazole ODT that is not expected to occur with Opipza film?	<input type="checkbox"/> Yes – <i>Submit documentation of contraindication/intolerance.</i> <input type="checkbox"/> No

REQUEST FOR A PATIENT LESS THAN 18 YEARS OF AGE

- 5. For renewal requests, has the patient had improvement in target symptoms with use of this medication? Yes No
- 6. Is this request for a dose increase of a previously approved medication or request over the plan limits? Yes – *Submit recent chart documentation and/or treatment guidelines supporting the requested dose.* No
- 7. For renewal requests, is there a plan for taper/discontinuation or rationale for continued use of requested drug ? Yes *Submit supporting documentation.* No
- 8. Is the requested agent prescribed by, or in consultation with, one of the following physician specialists? Yes No *Submit documentation of consultation, if applicable.*
 child development pediatrician child & adolescent psychiatrist general psychiatrist (only if patient is ≥ 14 years of age) pediatric neurologist
- 9. Does the patient have severe symptoms related to a psychotic or neuro-developmental disorder? Yes – *Submit medical record documentation.* No
- 10. Has chart documented evidence of comprehensive evaluation and plan of care that includes non-drug therapies? Yes – *Submit medical record documentation.* No
- 11. For a drug with risk of metabolic changes: Has the patient had the following baseline and/or follow-up monitoring? Check all that apply.
 BMI and/or weight (for follow-up monitoring this must be done quarterly) blood pressure fasting blood glucose or hemoglobin a1c fasting lipid panel
 presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)
Submit documentation of all monitoring/test results and dates.

REQUEST FOR THERAPEUTIC DUPLICATION OF AN ATYPICAL OR TYPICAL ANTIPSYCHOTIC

- 12. Does the patient have a medical reason for concomitant use of the requested medications? Yes – *Submit documentation of treatment guidelines supporting concomitant use.* No

- 13. Is this request for a drug that is being titrated to, or tapered from, a drug in the same class? Yes No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:
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