UnitedHealthcare Community Plan

Antipsychotics - Pennsylvania
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have a history of therapeutic failure, contraindication, or intolerance (such as, but not limited to, diabetes, obesity, etc.) of the preferred antipsychotics?** *(If yes, complete Section D above)*
□ Yes □ No	**Does the patient have a current history (within the past 90 days) of being prescribed the same non-preferred antipsychotic?**
INVEGA (PALIPERIDONE ER)	
□ Yes □ No	**Does the patient have active liver disease with elevated liver function tests (LFTs) or is at risk for active liver disease?**
LESS THAN 18 YEARS OF AGE	
□ Yes □ No	**Does the patient have severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses?** *(If yes, check which applies)* □ Autism spectrum disorder □ Intellectual disability □ Conduct disorder □ Bipolar disease □ Tic disorder, including Tourette's syndrome □ Transient encephalopathy □ Schizophrenia
□ Yes □ No	**Is the requested medication being prescribed by or in consultation with one of the following?** *(If yes, check which applies)* □ Pediatric neurologist □ Child and adolescent psychiatrist □ Child development pediatrician □ General psychiatrist
□ Yes □ No	**Does the patient have chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies such as, but not limited to, evidence-based behavioral, cognitive, and family based therapies?**
□ Yes □ No	**Does the patient have documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)?**
CONTINUATION OF THERAPY – LESS THAN 18 YEARS OF AGE	
□ Yes □ No	**Does the patient have documented improvement in target symptoms?**
□ Yes □ No	**Does the patient have documented monitoring of weight or body mass (BMI) quarterly?**
□ Yes □ No	**Does the patient have documented monitoring of blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS) after the first 3 months of therapy and then annually?**
□ Yes □ No	**Is there a documented plan for taper/discontinuation of the antipsychotic or rationale for continued use?**

Provider Signature: _____ **Date:** _____