State of Maine Department of Health & Human Services
MaineCare/MEDEL Prior Authorization Form
ATYPICAL ANTIPSYCHOTIC NECESSITY FORM

Phone: 1-888-445-0497 **www.mainecarepdl.org** Fax: 1-888-879-6938

Member ID #: |__|__|__|__|__|__|__|__|__|__|__| (NOT MEDICARE NUMBER) Patient Name: _____ DOB: _____

Patient Address:_____

Provider DEA: |__|__|__|__|__|__|__|__|__| Provider NPI: __|__|__|__|__|__|__|__|__|__|

Provider Name:_____ Phone:_____

Provider Address:_____ Fax:_____

Pharmacy Name:_____Rx Address:_____Rx phone:_____

Provider must fill all information above. It must be legible, correct and complete or form will be returned.

(Pharmacy use only): NPI: __|__|__|__|__|__|__|__|__|__| NABP: |__|__|__|__|__|__|__| NDC: |__|__|__|__|__|__|__|__|__|__|__|

Members under 5 years of age require prior authorization please submit chart notes with specific symptoms that support diagnosis and necessity and,

Members under 17 years of age require that the prescriber perform a timely assessment and ongoing monitoring of metabolic and neurologic variables of the patient in accordance with the ADA/APA monitoring guidelines.
https://www.psychiatrictimes.com/view/metabolic-monitoring-patients-antipsychotic-medications

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply	Circle Refills
PREFERRED					
❑ _____	_____	_____	_____	_____	1 2 3 4 5
NON-PREFERRED					
❑ _____	_____	_____	_____	_____	1 2 3 4 5

The following are listed as preferred on the PDL: Aripiprazole, Latuda, Fanapt, Aristada, Ziprasidone, Risperidone, Quetiapine, Olanzapine, and Clozapine.

The following are listed as non-preferred on the PDL: Abilify Inj, Tab and Sol, Invega,Risperdal, Saphris, Seroquel Zyprexa Zydis, Clozaril, Fazaclo.

Medical Necessity Documentation

Diagnosis (Check all that apply)

- ❑ Aggression (maximize psychosocial treatment and maximize pharmacologic treatment of the primary underlying diagnosis)
- ❑ Agitation Associated with Autism
- ❑ Bipolar Disorder
- ❑ Major Depression (as augmentation to an antidepressant after failure of two antidepressants from two distinct classes)
- ❑ Schizophrenia
- ❑ Schizoaffective Disorder
- ❑ Other (please specify) _____

1. List other medications tried before prescribing an atypical antipsychotic_____
   _____

Baseline levels are required and approvals will be limited. Subsequent approvals will require additional levels being done to assess changes. Lab results submitted should be dated (most recent).

2. List patient's Weight and Body Mass Index (kg/m^2) Baseline-Weight_____ BMI_____ Date_____
   Current- Weight_____ BMI_____ Date_____
   http://www.calculator.net/bmi-calculator.html

3. List patient's Blood Pressure: Baseline- _____ Date _____
   Current- _____ Date_____

4. List values of lipid profile and hemoglobin A1c (Supply dates of most recent labs)

HgA1c Baseline _____ Date_____ Current_____ Date_____
Cholesterol Baseline_____ Date _____Current_____ Date_____
Triglycerides Baseline_____ Date _____Current _____Date_____
HDL Baseline _____ Date _____Current _____Date_____
LDL Baseline _____ Date _____Current_____ Date_____

Note: The provider by prescribing an antipsychotic medication ensures that there is an appropriate indication for using the medication. The prescriber also attest to following the ADA/APA monitoring guidelines and that the risk of using the medication continues to outweigh the risk of not using the medication or Patient and/or guardian refused metabolic monitoring; despite this, the risks of using the antipsychotic still, in my judgment, outweigh the risks of not using the medication. I attest that I have obtained baseline BMI and lab studies for lipid and metabolic parameters as well as follow-up studies.

Pursuant to the MaineCare Benefits Manual, Chapter I, Section 1.16, The Department regards adequate clinical records as essential for the delivery of quality care, such comprehensive records are key documents for post payment review. Your authorization certifies that the above request is medically necessary, meets the MaineCare criteria for prior authorization, does not exceed the medical needs of the member and is supported in your medical records.

Provider Signature: _____ Date of Submission: _____
***MUST MATCH PROVIDER LISTED ABOVE**