State of Maine Department of Health &Human Services
MaineCare/MEDEL Prior Authorization Form
MULTIPLE ANTIPSYCHOTICS- Clinical PA

Phone: 1-888-445-0497 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: |__|__|__|__|__|__|__|__|__|__|__|
NDC: |__|__|__|__|__|__|__|__|__|__|__|
NDC: |__|__|__|__|__|__|__|__|__|__|__|

Treatment resistance is defined as little or no symptomatic response to multiple (at least two) antipsychotic monotherapy trials of an adequate duration (at least 6 weeks) and dose (therapeutic range). Multiple antipsychotic monotherapy trials may become necessary either due to persistent symptoms (treatment resistance) or due to intolerable side effects with psychotic/ affective illness. APA practice guidelines and the TMAP algorithm for schizophrenia each recommends at least 3 adequate trials of therapy with a single antipsychotic medication, including a trial of clozapine for schizophrenia, before considering augmentation/ polypharmacy. The use of two antipsychotics is considered at last stage (Stage 6) option.

Drug Name	Strength	Dosage Instructions	Quantity	Days Supply (34 retail / 90 mail order)	Refills
ANTIPSYCHOTIC 1_____	_____	_____	_____	_____	1 2 3 4 5
ANTIPSYCHOTIC 2_____	_____	_____	_____	_____	1 2 3 4 5
ANTIPSYCHOTIC 3_____	_____	_____	_____	_____	1 2 3 4 5

Medical Necessity Documentation Required:

1. What is the member's medical diagnosis? _____

2. One of the following criteria required for approval: (please submit supporting chart notes)

- ❑ The member has a history of psychotic/ affective illness and was discharged from last hospitalization on this combination.
- ❑ The member has a psychotic mental illness and has failed on clozapine.
- ❑ The member is using an atypical antipsychotic for psychotic/ affective illness and a typical antipsychotic for aggression or agitation.
- ❑ The member has used one antipsychotic to maximum tolerated dosage with some clinical benefit and has evidence of continued psychosis before adding the second.
- ❑ The member was cross-tapered from one antipsychotic to another and the prescriber tried to discontinue one of the drugs, but the member became psychotic.
- ❑ The member has come from another state and is new to MaineCare, (a 6-month approval will be granted allowing time for medication changes or submission of further documentation for continuation of multiple antipsychotic therapy).

Other medical necessity_____

_____

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**