



## 30-Day Prior Authorization Request Form for NTXIX/XXI SMI Brand Atypical Antipsychotics for Bridging

*Disclaimer: This form is for formulary branded atypical antipsychotics for NTXIX/XXI SMI Recipients to safely bridge to the generic formulary. Other branded medications, such as stimulants or antidepressants, will not be reviewed. Prior Authorizations will be reviewed for a maximum of 90 days in a year for oral atypical antipsychotics.*

Please fax all Prior Authorization requests for medications to the Magellan Pharmacy Helpdesk at **866-498-0628**  
Only one medication request per form • All fields must be complete and legible for review

*Please allow one business day to process all non-urgent requests for medications. If the request is urgent, please call 800-790-1631.*

All requests for reconsideration, regardless of reason, should be faxed to 866-498-0628 clearly marked "Reconsideration Request"

PRESCRIBER	PRESCRIBER NPI	RECIPIENT	RECIPIENT ID NUMBER (CIS OR AHCCCS ID)
	PRESCRIBER NAME		RECIPIENT NAME
	PRESCRIBER SPECIALTY		RECIPIENT DATE OF BIRTH (MM/DD/YYYY)
	CLINIC NAME		FEMALE MALE
	OFFICE PHONE		RECIPIENT SEX (CIRCLE)      HEIGHT      WEIGHT
	OFFICE FAX		RECIPIENT PHONE
CONTACT NAME	RECIPIENT DIAGNOSIS (AXIS I – III)	RECIPIENT DRUG ALLERGIES	

*Please check the medication requested for the patient:*

REQUEST	<input type="checkbox"/> ABILIFY®	<b>ORAL</b>
	MEDICATION NAME      STRENGTH AND FORM      ROUTE OF ADMINISTRATION      FREQUENCY	
	<input type="checkbox"/> GEODON®	<b>ORAL</b>
	MEDICATION NAME      STRENGTH AND FORM      ROUTE OF ADMINISTRATION      FREQUENCY	
	<input type="checkbox"/> SEROQUEL® <input type="checkbox"/> SEROQUEL XR®	<b>ORAL</b>
MEDICATION NAME      STRENGTH AND FORM      ROUTE OF ADMINISTRATION      FREQUENCY		
<input type="checkbox"/> ZYPREXA® <input type="checkbox"/> ZYPREXA ZYDIS®	<b>ORAL</b>	
MEDICATION NAME      STRENGTH AND FORM      ROUTE OF ADMINISTRATION      FREQUENCY		
DATE THERAPY INITIATED (MM/DD/YYYY)	EXPECTED LENGTH OF THERAPY	QUANTITY PER FREQUENCY

*Please indicate "YES" or "NO" to the following questions:*

RATIONALE FOR PRIOR AUTHORIZATION	<input type="checkbox"/> YES <input type="checkbox"/> NO	Is the recipient currently taking a brand atypical antipsychotic medication?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Has the recipient not successfully or fully transitioned to an alternative antipsychotic generic medication(s) due to clinical and/or safety concerns?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the recipient have an alternative funding source (including Medicare Part D) for the brand atypical antipsychotic medication?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Has the recipient lost AHCCCS enrollment and reapplied?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the recipient have a transition plan to move to a generic medication? If "YES", please list the generic medication and explain the transition plan below.
	MEDICATION NAME      STRENGTH AND FORM      ROUTE OF ADMINISTRATION      FREQUENCY	
EXPLAIN TRANSITION PLAN		
PRESCRIBER'S SIGNATURE	DATE	

*By signing this form, the prescriber is attesting that documentation supporting the above information is recorded in the Patient's Medical Chart.*

*Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents*