



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
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
	PRESCRIBER NAME
	PRESCRIBER SPECIALTY
	CLINIC NAME
	OFFICE PHONE
	OFFICE FAX
	CONTACT NAME

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

REQUEST	<i>Please check the medication requested for the patient:</i>			
	<input type="checkbox"/> ABILIFY®		ORAL	
	MEDICATION NAME	STRENGTH AND FORM	ROUTE OF ADMINISTRATION	FREQUENCY
	<input type="checkbox"/> GEODON®		ORAL	
	MEDICATION NAME	STRENGTH AND FORM	ROUTE OF ADMINISTRATION	FREQUENCY
	<input type="checkbox"/> SEROQUEL® <input type="checkbox"/> SEROQUEL XR®		ORAL	
MEDICATION NAME	STRENGTH AND FORM	ROUTE OF ADMINISTRATION	FREQUENCY	
<input type="checkbox"/> ZYPREXA® <input type="checkbox"/> ZYPREXA ZYDIS®		ORAL		
MEDICATION NAME	STRENGTH AND FORM	ROUTE OF ADMINISTRATION	FREQUENCY	
DATE THERAPY INITIATED (MM/DD/YYYY)	EXPECTED LENGTH OF THERAPY	QUANTITY PER FREQUENCY		

RATIONALE FOR PRIOR AUTHORIZATION	<i>Please indicate "YES" or "NO" to the following questions:</i>		
	<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
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.

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