Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Aetna Better Health of KS
PA Pharmacy Phone 855-221-5656
PA Pharmacy Fax 844-807-8453
PA Medical Phone 855-221-5656
PA Medical Fax 855-225-4102

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-943-6474

ANTIPSYCHOTIC PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

CHECK ONE: □ Drug dispensed from a pharmacy (pharmacy benefit)
□ Drug administered in an office or outpatient setting (medical benefit)

MEMBER INFORMATION

Name:	Medicaid ID:
Date of Birth:	Gender:

PRESCRIBER INFORMATION

Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf
- KS NDC lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp
- KS HCPCS lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:

1. Complete **the Member/Prescriber Information** portion above and **Sections I and II** for **ALL** requests
2. Complete **Section III** if this request requires a **peer-to-peer review**.
3. Complete **Section IV** if this request is a **renewal.**
4. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Select the appropriate medication(s) for this request:

□ Aripiprazole (Abilify®, Abilify Discmelt®, Abilify Maintena®, Aristada®, Aristada Initio™, Abilify MyCite®)
□ Asenapine (Saphris®, Secuado®)
□ Brexpiprazole (Rexulti®)
□ Cariprazine (Vraylar®)
□ Chlorpromazine
□ Clozapine (Clozaril®, Fazaclo®, Versacloz®)
□ Fluphenazine
□ Haloperidol (Haldol®)
□ Iloperidone (Fanapt®)
□ Loxapine (Adasuve®, Loxitane®)
□ Lumateperone (Caplyta®)
□ Lurasidone (Latuda®)
□ Olanzapine (Zyprexa®, Zyprexa Zydis®)
□ Olanzapine pamoate (Zyprexa Relprevv®)
□ Olanzapine/Fluoxetine (Symbyax®)
□ Paliperidone (Invega®)
□ Paliperidone palmitate (Invega Sustenna®, Invega Trinza®)
□ Perphenazine
□ Pimozide (Orap®)
□ Quetiapine (Seroquel®, Seroquel XR®)
□ Risperidone (Perseris™, Risperdal®, Risperdal Consta®, Risperdal M-Tab®)
□ Thioridazine
□ Thiothixene
□ Trifluoperazine
□ Ziprasidone (Geodon®)

PATIENT NAME:		MEDICAID ID:	

SECTION I: MEDICATION REQUESTED (continued)

NDC/HCPCS (J Code)	Strength	Dosage Form	Quantity	Directions for Use

Indication/Diagnosis:

Is the requested medication being prescribed for an FDA-approved indication? ☐ YES ☐ NO

Indication: _____

ICD-10: _____

Patient's weight: _____ ☐ lbs. ☐ kg

SECTION II: CLINICAL INFORMATION – For ALL Requests

1. Is this a new or renewal request for this medication?
   - ☐ New
   - ☐ Renewal – Proceed to section IV.

PROVIDER TYPE/DIAGNOSIS:

2. Is the patient < 6 years of age? ☐ YES ☐ NO – skip to question 3.
   - A. Document the prescribing physician's specialty.
     - ☐ Developmental-Behavioral Pediatrician ☐ Neurologist ☐ Psychiatrist ☐ Other
       - I. If other: Has the prescribing provider consulted/collaborated with one of the provider specialties listed above in question 2.A.?
         - ☐ YES – If YES, please document the provider's name, specialty and date of consult:
           Provider Name: _____ Specialty: _____ Date of Consult: _____
         - ☐ NO
   - B. Does the patient have symptoms of severe aggression secondary to mental health diagnosis (hostile or violent behavior directed at oneself or others such as physical aggression or property destruction)? ☐ YES ☐ NO
   - C. Proceed to question 3.

3. Is the patient < 18 years of age? ☐ YES ☐ NO – skip to question 4.
   - A. What is the patient's diagnosis for the requested medication?
     - ☐ Autism Spectrum Disorder ☐ Mood Disorder ☐ Psychotic Disorder ☐ PTSD with Associated Severe Agitation
     - ☐ Tic Disorder (i.e. Tourette's Disorder) ☐ Other – Specify diagnosis: _____
   - B. Proceed to question 5.

4. Is the patient ≥ 65 years of age (long-term care, non-dual eligibility group)? ☐ YES ☐ NO – skip to question 5
   - A. Please indicate the patient's diagnosis for the requested medication.
     - ☐ Adjunctive Treatment of Major Depressive Disorder ☐ Bipolar Disorder
     - ☐ Huntington's Disease ☐ Irritability Associated with Autistic Disorder
     - ☐ Schizophrenia, Schizoaffective, Delusional Disorder ☐ Tourette's Syndrome
     - ☐ Unspecified Psychotic Disorders ☐ Other – Specify diagnosis: _____
   - B. Does the patient have dementia/major neurocognitive disorder with agitation or psychosis whose symptoms present a danger to self or others?
     - ☐ YES ☐ NO

PATIENT NAME:		MEDICAID ID:	

MULTIPLE CONCURRENT USE:

5. For patients < 18 years of age, is the patient receiving 2 or more antipsychotics (oral and injectable) concurrently for greater than 60 days? ☐ YES ☐ NO ☐ Patient ≥ 18 years
   A. If YES, written peer-to-peer review is required. Please complete Section III.
   B. If YES, Is this medication being prescribed by or in consultation/collaboration with a psychiatrist, neurologist or developmental-behavioral pediatrician? ☐ YES ☐ NO
6. For patients ≥ 18 years of age, is the patient receiving 3 or more antipsychotics (oral and injectable) concurrently for greater than 60 days? ☐ YES ☐ NO ☐ Patient < 18 years
   A. If YES, written peer-to-peer review is required. Please complete Section III.
   B. If YES, Is this medication being prescribed by or in consultation/collaboration with a psychiatrist? ☐ YES ☐ NO
7. For patients ≥ 18 years of age, is the patient receiving 2 or more long-acting injectable antipsychotics concurrently for greater than 60 days? ☐ YES ☐ NO ☐ Patient < 18 years
   A. If YES, written peer-to-peer review is required. Please complete Section III.

SECTION II: CLINICAL INFORMATION – For ALL Requests (continued)

DOSING LIMITATION:

8. Does the dose prescribed exceed the maximum daily dosing limit defined in Table 1 (page 4)? ☐ YES ☐ NO
   A. If YES, written peer-to-peer review is required. Please complete Section III.

STEP THERAPY:

9. Abilify MyCite®
   A. Meets FDA label requirements for approved use. ☐ YES ☐ NO
   B. Documented benefit and no contraindication to aripiprazole tablets. ☐ YES ☐ NO
   C. Not able to receive injections. ☐ YES ☐ NO
   D. Requires peer-to-peer review. Please complete Section III. ☐ YES ☐ NO
10. All step therapies

Please list all medications the patient has previously tried and failed for treatment of this diagnosis.
*Specify medication name, reason for discontinuation (i.e. inadequate response, allergy, contraindication, intolerance) and dates of previous trial.

Medication Name	Reason for Discontinuation	Dates of Trial

SECTION III: PEER-TO-PEER REVIEW

PLEASE NOTE:

- A written peer-to-peer review will be followed by a verbal peer-to-peer review with a health plan psychiatrist, medical director, or pharmacy director for approval if the written request is not approved.

(Provide any/all clinical rationale/justification for this request (i.e. documentation, chart notes, prior therapy, etc.)

☐ PEER-TO-PEER WRITTEN:

_____
_____
_____
_____

☐ PEER-TO-PEER VERBAL

PATIENT NAME:		MEDICAID ID:	

SECTION IV: RENEWAL

1.	Is the patient stable?	☐ YES	☐ NO
2.	Has the patient been seen by the prescribing provider within the past year?	☐ YES	☐ NO
3.	Does the prescriber ATTEST that he/she has attempted to gather documentation of each of the following within the previous 12 months: fasting plasma glucose, height, weight, lipid screening, abnormal involuntary movement scale (AIMS) evaluation?	☐ YES	☐ NO
4.	Does the prescriber ATTEST that he/she has attempted to taper to the lowest effective dose?	☐ YES	☐ NO

PRESCRIBER SIGNATURE

☐ I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

PATIENT NAME:		MEDICAID ID:	

Note – General prescribing recommendations for antipsychotics in all ages:

- Prescriber should attempt to gather fasting plasma glucose, lipid screening, weight, height and Abnormal Involuntary Movement Scale (AIMS) evaluation within the previous 12 months.
- Documentation of developmentally-appropriate, comprehensive psychiatric assessment should be completed by the prescriber and documented in the child's medical record.
- Patient assessment should include DSM-5 or most updated edition of DSM diagnosis, screening for parental psychopathology, evaluation of family functioning and gathering collateral information from community resources (e.g. School).
- Non-psychopharmacological interventions (i.e. training parents or caregivers in evidence-based behavior management) should be initiated before (and maintained, if indicated, during) psychopharmacological treatment is initiated.

Table 1. Antipsychotic Medications Dosing Limits

Drug	Max Daily Dose* < 6yrs	Max Daily Dose* 6 To < 10yrs	Max Daily Dose* 10 To < 16yrs	Max Daily Dose* ≥ 16 To Adults
Aripiprazole (Abilify®, Abilify Discmelt®, Abilify MyCite®)	15mg	20mg	30mg	45mg
Aripiprazole (Abilify Maintena®)	Not approved	Not approved	Not approved	400mg per 28 days
Aripiprazole lauroxil (Aristada®)	Not approved	Not approved	Not approved	882mg per 28 days or 1064 every 2 months
Aripiprazole lauroxil (Aristada Initio™)	Not approved	Not approved	Not approved	675 mg single dose
Asenapine (Saphris®)	Not approved	10mg	20mg	20mg
Asenapine (transdermal)(Secuado®)	Not approved	Not approved	Not approved	7.6mg/24h
Brexpiprazole (Rexulti®)	Not approved	Not approved	Not approved	4mg
Cariprazine (Vraylar®)	Not approved	Not approved	Not approved	6mg
Chlorpromazine (oral)	40mg	200mg	800mg	1500mg
Clozapine (Clozaril®, Fazaclo®, Versacloz®)	Not approved	300mg	600mg	900mg
Fluphenazine (oral)	Not approved	5mg	10mg	60mg
Fluphenazine HCL and Decanoate (injection)	Not approved	Not approved	Not approved	100mg
Haloperidol (Haldol®)	6mg or 0.15mg/kg/day ("Lesser of")	6mg	15mg	60mg
Haloperidol Decanoate (Haldol® Decanoate)	Not approved	Not approved	Not approved	500mg per 21 days
Iloperidone (Fanapt®)	Not approved	12mg	24mg	24mg
Loxapine (Loxitane®)	Not approved	30mg	60mg	250mg
Loxapine (Adasuve®)	Not approved	Not approved	Not approved	10mg
Lumateperone (Caplyta®)	Not approved	Not approved	Not approved	42mg
Lurasidone (Latuda®)	Not approved	80mg	120mg	160mg
Olanzapine (Zyprexa®, Zyprexa Zydis®)	Not approved	12.5mg	20mg	40mg
Olanzapine pamoate (Zyprexa Relprevv®)	Not approved	Not approved	Not approved	300mg per 14 days or 405 mg every 28 days
Olanzapine/Fluoxetine (Symbyax®)	Not approved	Not approved	12mg/50mg	18mg/75mg
Paliperidone (Invega®)	Not approved	6mg	12mg	12mg
Paliperidone palmitate (Invega Sustenna®)	Not approved	Not approved	Not approved	234mg per 21 days
Paliperidone palmitate (Invega Trinza®)	Not approved	Not approved	Not approved	819mg per 84 days
Perphenazine	Not approved	12mg	22mg	64mg
Pimozide (Orap®)	Not approved	6mg or 0.2mg/kg/day ("Lesser of")	10mg or 0.2mg/kg/day ("Lesser of")	20mg
Quetiapine (Seroquel®, Seroquel XR®)	Not approved	400mg	800mg	1200mg
Risperidone (Perseris™)	Not approved	Not approved	Not approved	120 mg per 28 days
Risperidone (Risperdal®, Risperdal M-Tab®)	1.5mg	4mg	6mg	16mg
Risperidone (Risperdal Consta®)	Not approved	Not approved	Not approved	50mg per 14 days
Thioridazine	Not approved	Not approved	Not approved	800mg
Thiothixene	Not approved	Not approved	15mg	60mg
Trifluoperazine	Not approved	15mg	40mg	40mg
Ziprasidone (Geodon®)	Not approved	80mg	160mg	240mg

*Daily dose unless specified