ANTIPSYCHOTICS
PRIOR AUTHORIZATION FORM
(form effective 1/6/2025)

Keystone First
Community HealthChoices

PERFORMRx℠
Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-855-851-4058**, or to speak to a representative, call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total pages:	Office contact/phone:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID#:	DOB:
Street address:	Apt #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:			
Specialty:	NPI:		State license #:
Street address:	Suite #:	City/state/zip:	
Phone:	Fax:		

MEDICATION REQUESTED

Preferred Agents

Non-Injectable

☐ Aripiprazole Tablet	☐ Haloperidol Tablet	☐ Olanzapine Tablet	☐ Risperidone Solution
☐ Clozapine Tablet	☐ Haloperidol Lactate Oral Concentrate Solution	☐ Paliperidone ER Tablet	☐ Risperidone Tablet
☐ Equetro (carbamazepine) Capsule		☐ Perphenazine Tablet	☐ Trifluoperazine Tablet
☐ Fluphenazine Oral Concentrate Solution	☐ Loxapine Capsule	☐ Quetiapine Tablet	☐ Ziprasidone Capsule
☐ Fluphenazine Tablet	☐ Lurasidone Tablet	☐ Quetiapine ER Tablet	

Injectable

☐ Abilify Asimtufii (aripiprazole)	☐ Fluphenazine Decanoate Vial	☐ Haloperidol Lactate Vial	☐ Perseris ER (risperidone)
☐ Abilify Maintena (aripiprazole)	☐ Haloperidol Decanoate Ampule	☐ Invega Hafyera (paliperidone)	☐ Risperdal Consta (risperidone)
☐ Aristada ER (aripiprazole lauroxil)	☐ Haloperidol Decanoate Vial	☐ Invega Sustenna (paliperidone)	☐ Rykindo (risperidone) Vial
☐ Aristada Initio (aripiprazole lauroxil)	☐ Haloperidol Lactate Syringe	☐ Invega Trinza (paliperidone)	☐ Uzedy ER (risperidone)

Strength:	Dosage form:	Directions:
Diagnosis:		

Non-Preferred Agents

Non-Injectable

☐ Abilify (aripiprazole) Tablet	☐ Clozaril (clozapine) Tablet	☐ Olanzapine ODT	☐ Seroquel XR (quetiapine) Tablet
☐ Abilify Mycite (aripiprazole tablet + sensor)	☐ Fanapt (iloperidone) Tablet	☐ Olanzapine-Fluoxetine Capsule	☐ Symbyax (olanzapine-fluoxetine) Capsule
☐ Adasuve (loxapine) Inhalation Powder	☐ Fluphenazine Elixir	☐ Perphenazine-Amitriptyline Tablet	☐ Thioridazine Tablet
☐ Aripiprazole ODT	☐ Geodon (ziprasidone) Capsule	☐ Pimozide Tablet	☐ Thiothixene Capsule
☐ Aripiprazole Solution	☐ Invega ER (paliperidone) Tablet	☐ Rexulti (brexpiprazole) Tablet	☐ Versacloz (clozapine) Suspension
☐ Asenapine SL Tablet	☐ Latuda (lurasidone) Tablet	☐ Risperdal (risperidone) Solution	☐ Vraylar (cariprazine) Capsule
☐ Caplyta (lumateperone) Capsule	☐ Lybalvi (olanzapine/samidorphan) Tablet	☐ Risperdal (risperidone) Tablet	☐ Zyprexa (olanzapine) Tablet
☐ Chlorpromazine Concentrate Solution	☐ Molindone Tablet	☐ Risperidone ODT	☐ Zyprexa (olanzapine) Zydis
☐ Chlorpromazine Tablet	☐ Nuplazid (pimavanserin) Capsule	☐ Saphris SL (asenapine) Tablet	
☐ Clozapine ODT	☐ Nuplazid (pimavanserin) Tablet	☐ Secuado (asenapine) Patch	
		☐ Seroquel (quetiapine) Tablet	

Injectable

☐ Chlorpromazine Ampule	☐ Geodon (ziprasidone) Vial	☐ Risperidone ER Vial	☐ Zyprexa Relprevv (olanzapine)
☐ Chlorpromazine Vial	☐ Haldol Decanoate (haloperidol) Ampule	☐ Ziprasidone Vial	☐ Zyprexa (olanzapine) Vial
☐ Fluphenazine HCl Vial	☐ Olanzapine Vial		

Strength:	Dosage form:	Directions:
Diagnosis:		

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:	
Pharmacy Phone #:	Pharmacy Fax #:
☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.	

REQUEST FOR A NON-PREFERRED AGENT

1. Has the patient taken the requested non-preferred antipsychotic in the past 90 days?	☐ Yes – *Submit documentation.*	☐ No
2. Has the patient tried and failed the preferred medications (listed above)?	☐ Yes – List medications tried:	☐ No
3. Does the patient have a contraindication or intolerance to the preferred medications?	☐ Yes – *Submit documentation of contraindication/intolerance.*	☐ No

REQUEST FOR A PATIENT LESS THAN 18 YEARS OF AGE

4. For renewal requests, has the patient had improvement in target symptoms with use of this medication? ☐ Yes ☐ No

5. Is this request for a dose increase of a previously approved medication or request over the plan limits? ☐ Yes – *Submit recent chart documentation and/or treatment guidelines supporting the requested dose.* ☐ No

6. For renewal requests, is there a plan for taper/discontinuation or rationale for continued use of requested drug ? ☐ Yes Submit supporting documentation. ☐ No

7. Is the requested agent prescribed by, or in consultation with, one of the following physician specialists? ☐ Yes ☐ No *Submit documentation of consultation, if applicable.*
☐ child development pediatrician ☐ child & adolescent psychiatrist ☐ general psychiatrist (only if patient is ≥ 14 years of age) ☐ pediatric neurologist

8. Does the patient have severe symptoms related to a psychotic or neuro-developmental disorder? ☐ Yes – *Submit medical record documentation.* ☐ No

9. Has chart documented evidence of comprehensive evaluation and plan of care that includes non-drug therapies? ☐ Yes – *Submit medical record documentation.* ☐ No

10. Has the patient had the following baseline and/or follow-up monitoring? Check all that apply. ☐ BMI and/or weight (for follow-up monitoring this must be done quarterly) ☐ blood pressure ☐ fasting blood glucose or hemoglobin a1c ☐ fasting lipid panel ☐ presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)
Submit documentation of all monitoring/test results and dates.

REQUEST FOR THERAPEUTIC DUPLICATION OF AN ATYPICAL OR TYPICAL ANTIPSYCHOTIC

11. Does the patient have a medical reason for concomitant use of the requested medications? ☐ Yes – *Submit documentation of treatment guidelines supporting concomitant use.* ☐ No

12. Is this request for a drug that is being titrated to, or tapered from, a drug in the same class? ☐ Yes ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date: