BANK'S APOTHECARY

Specialty Pharmacy

Atypical Antipsychotic Long-Acting Injectables
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:
Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone	Office Fax:	
Dispensing Pharmacy Information			
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:	
Turn-Around Time for Review			
☐ Standard – (24 hours)	☐ Urgent – Waiting 24 hours for standard decision could seriously harm life, health, or ability to regain maximum function; you are requesting an expedited decision. Signature:		

Requested Medication Information			
Formulary	☐ Abilify Maintena	☐ Aristada	☐ Invega Sustenna
	☐ Invega Trinza	☐ Risperdal Consta	☐
Non-Formulary	☐ Aristada Initio	☐ Perseris	☐ Zyprexa Relprevv
Other, specify drug			

☐ New request	☐ Continuation of therapy	Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes ☐ No ☐
Was the long acting antipsychotic started during recent hospitalization? (circle one): Yes ☐ No ☐		Was the recommended oral dosage received (per FDA approved labeling) to confirm tolerability and efficacy? Yes ☐ No ☐
What is the diagnosis ICD-10 Code?		Diagnosis:
What medication(s) were tried and failed for this diagnosis?		
Are there any contraindications to formulary medications? (If yes, please specify):		☐ Yes ☐ No

Directions for Use:	Strength:		Dosage Form:
	Quantity:	Day Supply:	Duration of Therapy/Use:

Clinical Information							
Was there non-adherence to oral antipsychotic medications; and this places member at risk for poor outcomes?						☐ Yes	☐ No
Will member receive concurrent oral antipsychotics after the initial overlap period?						☐ Yes	☐ No
Provider agrees to supports baseline and routine monitoring of ALL the following:						☐ Yes	☐ No
☐ Weight, BMI, or waist circumference	☐ BP	☐ Fasting Lipid Panel	☐ Fasting Glucose	☐ Tardive Dyskinesia using AIMS or DISCUS			
Is member taking a Cytochrome P450 3A4 (CYP3A4) inducer?	☐ Yes	☐ No	Was a metabolic screening completed within the last 60 days?			☐ Yes	☐ No

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required

Standard turnaround time is 24 hours. You can call to check the status of a request.
Pennsylvania: 1-866-638-1232.
Pennsylvania CHIP: 1-800-822-2447.