

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. Incomplete forms or forms without the chart notes will be returned

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Concomitant Antipsychotic Treatment Pharmacy Prior Authorization Request Form Do not copy for future use. Forms are updated frequently

·	st & last):		·											
Member ID:	Member Name (first & last):				Date of Birth:			Gender:				Height:		
Member ID:								Mal	е	□ Fe	emale			
	Member ID:				City:			State:				Weight:		
Prescribing Provid	der Informa	tion												
Provider Name (first & last):				S	Specialty:				NPI#			DEA#	DEA#	
Office Address:				C	City:				State:			Zip Cod	de:	
Office Contact:				C	Office Phone				Office Fax:					
Since Contact.									000 / 0./					
Dispensing Pharm	nacy Inform	ation												
Pharmacy Name:				P	Pharmacy Phone:				Pharmacy Fax:					
Turn-Around Time	•													
□ Standard – (2 ⁴	1 hours) [•	Vaiting 24 houl function; you a						-	life, he	ealth, or	ability to rega	iin	
Requested Medica	ation Inforn											_		
□ aripiprazole		aripiprazole		aripip	prazole)			aripiprazole			aripiprazole		
□ loxapine		loxapine		loxap	xapine			□ loxapine				□ loxapine		
□ perphenazine		perphenazii	ne 🗆	perpl	henazi	ine		□ perphenazine				□ perphenazine		
☐ Other (please	specify):													
Are there any contr	aindications	to formulary r	medications?		l Yes	 	No		New Reque	est 🗆	I Con	tinuation of th	erapy	
(If yes, please spec	= -													
Medications were s	tarted durin	g recent hospi	talization (circl	e one):							DA app	proved, or cor	npendi	
Yes No										No				
What is the diagnos	sis IDC-10 (Code?				Diagnos	sis:							
What medication(s)) were tried	and failed for t	his diagnosis?											
Directions for Use:														
O	D 0		D	1	./1.1.				4		.			
Quantity:	Day Suppl	y:	Duration of T	nerapy/	rapy/Use:			Strength: D			Dosa	Dosage Form:		

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For refractory schizophreni		m one medication to		☐ Ye	s 🗆 No 🗆	N/A					
	a Is there	evidence of adequat	te trials with	3 individua	l antidepressants lis	sted on the		Yes		No	
spectrum disorder:	formular	y?			·						
Were these trials for a period	of 4-6 weeks	at maximum tolerate	ed doses?					Yes		No	
Failures were due to ONE of	the	☐ Inadequate re	sponse at m	aximum	☐ Adverse reacti	on(s)		Break	thro	uah	
following:		☐ Inadequate response at maximum ☐ Adverse reaction(s) tolerated doses							☐ Break through symptoms		
_	Mara thans	trials of 4 evidence-		□ No	Mara thasa trials	for o		Yes		Nia	
For refractory bipolar	corder w/psychosis were there		☐ Yes	□ No	Were these trials for a period of 4-6 weeks at		ш	res		No	
					•						
and/or severe symptoms:	severe symptoms: dependent upon episode type? maximum tolerated dos					ea aoses?					
Failures were due to ONE of	the following:	☐ Inadequate r	ocpoped at		Adverse reaction(s)	☐ Break	(thro	ugh sy	mntor	mc	
I alidies were due to ONE of	the following.	maximum tol	•		Adverse reaction(s)	Diear	\ tillO	ugii sy	Πρισι	113	
Are there TMO different pro-	aribara nraaari				mad O			Vaa		Nia	
Are there TWO different pres	<u> </u>							Yes		No	
Is there documentation that a	idherence to ti	reatment regimen w	as not a con	tributing fa	ector to inadequate r	esponse to		Yes		No	
medication trials?											
Additional information the	prescribing p	rovider feels is imp	portant to th	is review.	Please specify be	low or subr	mit m	edical	reco	rds.	
Signature affirms that infor	mation given	on this form is tru	e and accur	ate and re	eflects office notes						
Signature affirms that infor		on this form is tru	e and accur	ate and re	eflects office notes	. 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 800-624-3879 to check the status of a request

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