Print Reset

NYRx the Medicaid Pharmacy Program

Atypical Antipsychotics (AAP) Prior Authorization Worksheet

Fax this form to 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete. Preferred drugs will not require PA if the required coverage parameters, outlined in the PDL, are found in the member's Medicaid claim history at the time of pharmacy claim submission. Non-preferred drugs will require PA. https://newyork.fhsc.com/

Enrollee Information

Enrollee Last Name: _____

Enrollee First Name: _____

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): _____

Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ Prescriber Fax: _____

REQUESTED DRUG INFORMATION

Drug Name: _____

Drug Strength: _____

Quantity: _____ Number of Refills: _____

Directions: _____

Is this a New Prescription?

☐ Yes ☐ No

If **No**, date therapy was initiated: _____

Enrollee's Name (Last, First): _____

CRITERIA

1. What is the patient's diagnosis?: _____

   ICD-10 diagnosis code: _____

2. Is the diagnosis an off-label use for this medication?

   ☐ Yes ☐ No

   If **Yes**, what is the clinical reason for off-label use?

   _____

For major depressive disorder (MDD)

3. Are you requesting Symbyax?

   ☐ Yes ☐ No

   If **Yes**, has the patient experienced a treatment failure or adverse reaction with at least 1 antidepressant other than fluoxetine?

   ☐ Yes ☐ No

   If **No**, has the patient experienced a treatment failure or adverse reaction with at least 2 different antidepressants?

   ☐ Yes ☐ No

4. If either selection is **No**, what is the clinical reason for use without meeting the required "trial of an antidepressant"?

   _____

For PDL questions (non-preferred medications)

5. Are you willing to prescribe a preferred agent?

   ☐ Yes ☐ No

   If **Yes**, please see Antipsychotics – Second Generation PDL class for a list of preferred agents (https://newyork.fhsc.com/)

6. Has the patient experienced treatment failure with a preferred atypical antipsychotic?

   ☐ Yes ☐ No

7. Has the patient experienced an adverse drug reaction with a preferred atypical antipsychotic?

   ☐ Yes ☐ No

Enrollee's Name (Last, First): _____

CRITERIA (CONTINUED)

8. Is there a documented history of successful therapeutic control with a non-preferred atypical antipsychotic and transition to a preferred atypical antipsychotic is medically contraindicated?

   ☐ Yes ☐ No

9. What is the reason the patient is unable to use a preferred agent in the same drug class? (if necessary, fax additional pages)

   _____

For Abilify MyCite

10. Are you attesting that the patient has a smart phone and has been taught how to use the app?

    ☐ Yes ☐ No

11. Has the patient experienced a treatment failure or adverse reaction to oral aripiprazole?

    ☐ Yes ☐ No

12. Has the patient experienced a treatment failure of adverse reaction to injectable aripiprazole?

    ☐ Yes ☐ No

    If **No**, what is the clinical reason the patient cannot use another formulation of aripiprazole?

    _____

For drugs with dose optimization limits (see posted PDL for dose optimization limits (https://newyork.fhsc.com/)

13. Does this request exceed the Dose Optimization limit?

    ☐ Yes ☐ No

14. Are you willing to use a higher strength (If **Yes**, skip question #16)?

    ☐ Yes ☐ No

15. What is the clinical reason for not using a higher available strength or exceeding the daily limit?

    _____

Enrollee's Name (Last, First): _____

CRITERIA (CONTINUED)

Frequency/quantity/duration (F/Q/D) limits (see posted PDL for limits)

Maximum dose criteria

16. Does the dose requested exceed the FDA maximum recommended dose?

☐ Yes ☐ No

If **Yes**, what is the clinical reason for exceeding the FDA-approved max daily dose (MDD)?

_____

Minimum dose criteria (quetiapine/quetiapine ER, Seroquel®/Seroquel XR®)

17. What is the clinical reason for prescribing a low dose of Seroquel that is under the minimum amount of 50 mg/day?

_____

Daily Quantity Limit (quetiapine/Seroquel®)

18. Does the dose requested exceed the established daily quantity limit?

☐ Yes ☐ No

If **Yes**, what is the clinical reason for exceeding the FDA-approved quantity limit?

_____

DUR EDITS

DUR – Concurrent use of CNS stimulants and atypical antipsychotic for patients < 18 years of age

19. What diagnosis requires the concurrent use of a CNS stimulant and an atypical antipsychotic?

_____

DUR – Concurrent use of 2 or more atypical antipsychotics for > 90 days for patients < 21 years of age

20. What are the names of the atypical antipsychotics?

_____

21. What is the clinical reason for the concurrent use of 2 or more oral atypical antipsychotics for > 90 days?

_____

22. Do you plan to discontinue any of the antipsychotics?

☐ Yes ☐ No

Enrollee's Name (Last, First): _____

DUR EDITS (CONTINUED)

If **Yes**, what is the drug name and approximate date of discontinuation?

Drug Name: _____

Date of Discontinuation: _____

DUR – Concurrent use of 3 or more atypical antipsychotics for > 180 days for patients ≥ 21 years of age

23. What are the names of the atypical antipsychotics?

_____

24. What is the clinical reason for the concurrent use of 3 or more oral atypical antipsychotics for > 180 days?

_____

25. Do you plan to discontinue any of the antipsychotics?

☐ Yes ☐ No

If **Yes**, which drug and what is the approximate date of discontinuation?

Drug(s): _____

Date of Discontinuation: _____

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

Fax Number: 800-268-2990

Billing Questions: 800-343-9000

For clinical concerns or Preferred Drug Program questions, please visit http://newyork.fhsc.com or call 877-309-9493.