Reset Form Print Form

MEDICATION PRIOR AUTHORIZATION REQUEST FORM
FAX this completed form to 1-833-546-1507
OR Mail request to: Pharmacy Services Prior Authorization Dept.
5 River Park Place East, Suite 210 | Fresno, CA 93720
Call 1-866-399-0928 to request a 72-hour supply of medication.
Pharmacy Services will respond via fax or phone within 24 hours of receipt of all necessary information, expect during weekends and holidays. For immediate response on weekends and holidays, NurseWise will answer your call.

ADULT ANTIPSYCHOTIC HIGH DOSE

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number - -

Prescriber's Fax Number - -

Drug, Dose and Frequency: _____

Diagnosis: _____

Previous Antipsychotic Trials (include drug, maximum dose, duration, and trial dates):

1. _____ _____
2. _____ _____
3. _____ _____

Rationale for high dose antipsychotic (check all that apply):

- ☐ Failure to respond to clozapine
- ☐ Failure to respond to clozapine with augmentation
- ☐ Failure to tolerate clozapine
- ☐ During the switch of one antipsychotic to another
- ☐ As a temporary measure during an acute episode
- ☐ Other: _____

Please provide the monitoring plan (including tapering schedule) in the space provided below.

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.