

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													Date of Birth (MM/DD/YYYY)														_		
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Recipient's Full Name																													
Prescriber's Full Name																													
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Dru	g, De	ose	and	Free	quei	ncy:																							
	Drug, Dose and Frequency:																												
									de d										trial _ _ _	date	es): 								
Rationale for high dose antipsychotic (check all that apply):																													
	☐ Failure to respond to clozapine☐ Failure to respond to clozapine with augment										tatio	n		During the switch of one antipsychotic to anotherAs a temporary measure during an acute episode															
☐ Failure to tolerate clozapine														☐ Other:													_		
Plea	ıse p	orov	ide 1	he r	non	itori	ng p	olan	(incl	udir	ng t	aper	ing	sche	dul	e) in	the	spa	ice p	rovi	ded	belo	ow.						
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.													it																

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