



Government of District of Columbia Department of Health Care Finance

Long Acting Injectable Atypical Antipsychotics

Initial Prior Authorization Request

REQUEST DATE: / /

PATIENT INFORMATION

PATIENT'S MEDICAID ID NUMBER

PATIENT'S DATE OF BIRTH

PATIENT'S FULL NAME

PRESCRIBER INFORMATION

PRESCRIBER'S FULL NAME

PRESCRIBER PHONE NUMBER:

PRESCRIBER FAX NUMBER:

PRESCRIBER SPECIALTY:

PRESCRIBER NPI #:

Please refer to the FDA-approved product information for the details of each drug's specific indications and limitations; drug-drug and drug-disease interactions; precautions, contraindications and black box warnings; and monitoring parameters.

PRESCRIBED DRUG INFORMATION

Name of the Drug Requested:

Strength:

Frequency of Administration:

Quantity:

INFORMATION REQUIRED FOR PRIOR AUTHORIZATION APPROVAL

- Patient's diagnosis: ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Depression ☐ Bipolar Disorder ☐ Mania ☐ Autism
☐ Other: _____
- The patient is 18 years of age or older. ☐ Yes ☐ No
- The patient is female. ☐ Yes ☐ No
- If the patient is female of a child-bearing age, she is adequately informed about precautions, warnings, and treatment risks versus benefits; and when relevant, the patient is advised to use effective contraceptive means? ☐ Yes ☐ No ☐ Not Applicable
- To the best of my knowledge, I am the only prescriber of antipsychotic medications for this patient. ☐ Yes ☐ No
☐ If no, please describe any communication and care coordination efforts among all providers: _____
- The patient has been tried on oral antipsychotic regimen and found to be no adherent or there is clear documentation that the patient cannot take oral antipsychotic drug. ☐ Yes ☐ No
 - Please provide patient specific reason(s) why the requested long-acting antipsychotic drug is expected to be effective. _____
 - Please provide the list of drugs patient has tried before _____
- The patient's ability to tolerate extended exposure to antipsychotics has been established by the use of oral antipsychotic drug as recommended in the FDA-approved product information prior to initiating the requested long-acting antipsychotic drug. ☐ Yes ☐ No
- If the request is INVEGA TRINZA™, has the patient been treated with the 1-month Invega sustenna (paliperidone palmitate) extended-release injectable suspension for at least four months before initiating treatment with INVEGA TRINZA™ (paliperidone palmitate) extended-release injectable suspension as recommended in the FDA-approved product information? ☐ Yes ☐ No
- Additional information helpful to submit with the Prior Authorization request include:
☐ Letter of Medical Necessity to clinically justify the request
☐ Adherence and treatment outcome evaluation and monitoring plans
☐ Relevant Diagnosis and Laboratory Test Results to rule out disease conditions such as severe renal impairment and dementia-related psychosis (please note that some may be applicable to all atypical antipsychotics while others are specific to each drug) ☐ Patient counseling and Education Plan

I certify that the above information is correct and accurate to the best of my knowledge and that the form is complete (please sign and date). I understand that I may be subject to civil penalties or criminal prosecutions for any falsification, omission, or concealment of any material fact contained herein.

PRESCRIBER'S SIGNATURE: _____ DATE: _____

FAX COMPLETED PA REQUEST FROM AND ALL NECESSARY DOCUMENTATIONS TO 1-866-535-7622