MARYLAND Department of Health

Maryland Medicaid Pharmacy Program
Tel: 1-855-283-0876
Fax:1-866-671-8084 or 1-410-618-4168

Request to Authorize Antipsychotic Prescription for Youth 17 and Younger

Patient Information

Patient Name: _____ _____ ____
Last name *First name* *MI*

Maryland Medicaid #: _____

☐ Male ☐ Female

DOB (mm/dd/yyyy): _____

Height (inches): _____ Date: _____

Weight (pounds): _____ Date:_____

Prescriber Information

Prescriber Name: _____ _____ ____
Last name *First name* *MI*

Treatment site or office address: _____

_____

Medical Specialty: _____

NPI #: _____

Tel: _____

Treatment site or office fax: _____

Alternate Contact (if applicable): _____

Antipsychotic for which authorization is being sought (please check)

Preferred Medications

☐ Abilify Maintena®
☐ aripiprazole
☐ chlorpromazine
☐ clozapine
☐ fluphenazine
☐ fluphenazine decanoate
☐ haloperidol
☐ haloperidol decanoate
☐ Invega Sustenna®
☐ Invega Trinza®
☐ loxapine
☐ olanzapine
☐ perphenazine
☐ quetiapine
☐ quetiapine XR
☐ risperidone
☐ thioridazine
☐ thiothixene
☐ trifluoperazine
☐ ziprasidone

Tier 2 Preferred Medication

☐ Latuda®

Non-Preferred Medications

☐ Aristada®
☐ Fanapt®
☐ olanzapine/fluoxetine
☐ paliperidone
☐ Saphris®
☐ Rexulti®
☐ Vraylar®
☐ Zyprexa Relprevv®

Antipsychotic: _____ Strength: _____ Regimen: _____ Total Daily Dose: _____

Antipsychotic: _____ Strength: _____ Regimen: _____ Total Daily Dose: _____

☐ The patient was recently treated in an inpatient, emergency or crisis setting. If so, date of discharge: _____

☐ This is a continuation or inpatient or emergency treatment. If so, date of initiation of antipsychotic: _____

☐ There is a plan to discontinue or taper an antipsychotic in this patient (specify antipsychotic): _____

DSM Diagnosis (please check all that apply)

☐ ADHD
☐ Autism Spectrum Disorder
☐ Bipolar Disorder
☐ Conduct Disorder
☐ Disruptive Mood Dysregulation Disorder
☐ Generalized Anxiety Disorder
☐ Intellectual Disability
☐ Major Depressive Disorder
☐ Obsessive Compulsive Disorder
☐ Oppositional Defiant Disorder
☐ Panic Disorder
☐ Psychotic Disorder (other)
Specify _____
☐ Posttraumatic Disorder
☐ Reactive Attachment Disorder
☐ Schizoaffective Disorder
☐ Schizophrenia
☐ Schizophreniform Disorder
☐ Substance Related/Addictive Disorder
☐ Tourette's Disorder
☐ Traumatic Brain Injury
☐ Other Disorder
Specify _____

Target Symptoms (please check all that apply)

☐ Aggression
☐ Anxiety
☐ Assault
☐ Delusions
☐ Depression
☐ Hallucinations
☐ Hyperactivity
☐ Impulsivity
☐ Insomnia
☐ Irritability
☐ Mania
☐ Mood Instability
☐ Self-injurious behavior
☐ Other Symptoms (specify):
_____
_____

The checked symptoms place the child at risk of:
☐ Hospitalization
☐ Out of home placement
☐ Suspension/expulsion from school
☐ Danger to self
☐ Danger to others
☐ None of the above

CONTINUED ON NEXT PAGE

Patient Name: _____

Laboratory Values, ECG and Rating Scale

Fasting Glucose:
Date:_____
Value:_____

Fasting Lipids:
Date:_____
Triglycerides:_____
LDL:_____
HDL:_____

Abnormal Involuntary Movement Scale:
Date:_____
Score:_____

Hepatic Function:
Date:_____
AST:_____
ALT:_____

A BASELINE ECG IS REQUIRED FOR ALL PATIENTS RECEIVING ZIPRASIDONE OR IF A PATIENT HAS HISTORY OF ANY OF THE FOLLOWING:

Personal history of syncope, palpitation cardiovascular abnormalities
☐ yes ☐ no
Positive family history of sudden death/cardiovascular abnormalities
☐ yes ☐ no

ECG Results (when applicable)
Date: _____ ☐ normal ☐ QTc value(msec): _____

☐other ECG abnormality (specify): _____

Please provide an explanation for any missing laboratory information: _____
_____

Non-Pharmacologic Treatment and Other Clinical Information

The patient is currently receiving non-pharmacologic/psychosocial services (may include school based services).
☐yes ☐no ☐referred and appointment pending

Please specify the type of non-pharmacologic/psychosocial services: _____

The patient has a known history of abuse or trauma. ☐ yes ☐ no

Other Psychopharmacologic Agents the Patient is Receiving

Medication	Strength/Frequency	Approximate Dates of Trial	Indication

Previous Antipsychotic Trials

Medication	Strength/Frequency	Approximate Dates of Trial	Indication

Continuation of Care and Certification

It is likely that this patient will be transferred to the care of another provider. ☐ yes ☐ no

If yes, to whom? _____

I certify that the benefits of antipsychotic treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge.

Prescriber Signature:_____ Date:_____