MedStar Medicare Choice
Pharmacy Services
Phone: 855-266-0712
Fax: 855-862-6517

ANTIPSYCHOTICS
(Aristada, Fanapt, paliperidone, Rexulti, Saphris, Seroquel XR, Versacloz, Vraylar)
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

Demographics

Patient Information			Prescriber Information	
Patient Name:			Prescriber Name:	
DOB:	Age:		NPI#:	Specialty:
Health Plan ID#:			Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:		Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Please indicate the diagnosis: Date Diagnosed:_____

□ Bipolar Disorder □ Schizophrenia □ Major Depression with Psychosis

□ Major Depressive Disorder □ Schizoaffective disorder □ Other:_____

History of Medications Used to Treat Above Condition

□ No other medications have been used to treat this condition

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below: