Injectable Antipsychotics
Request for Prior Authorization

Fax completed form to Cenpatico at **866-694-3649**. Upon receipt of all necessary information, Cenpatico will contact you by fax or phone within one business day. **No authorization is required for Haldol-D or Prolixin-D.**

PLEASE PRINT CLEARLY

Member Name: _____ **Prescriber:** _____
Member ID#: _____ **Phone:** _____
Member DOB: _____ **Fax:** _____

Primary Diagnosis:
Axis I: _____
Other Diagnoses:
Axis II: _____
Axis III: _____

☐ New Medication request **OR** ☐ Continuing Medication request

☐ **J2794 Risperdal Consta**

Dosage	Units requested	Frequency	Total Units
25mg	50	Q 2 weeks	_____
37.5mg	75	Q 2 weeks	_____
50mg	100	Q 2 weeks	_____

Other: _____

Circle All Applicable Criteria Specific to this Request For Risperdal Consta:

A. Patient is under court order for outpatient treatment and medications. Date of court order: _____

B. Patient has diagnosis of schizophrenia, schizoaffective disorder, bipolar disorder, or major depressive disorder with psychosis using DSM-IV criteria.

C. Patient has had prior trial on Haldol-D or Prolixin-D. Reason for discontinuing: _____

D. Patient has evidenced non-adherence to oral therapy, which has resulted in past hospitalizations. Dates: _____

E. Patient is currently on oral Risperdal therapy and/or has a history of responding to Risperdal. Dose and start date: _____

F. Patient has been prescribed Risperdal Consta prior to arrival to my practice, and is stable on the medication. Previous prescriber, dose, start date: _____

G. Dosage is less than 50 mg Q2 weeks.

☐ **J2426 Invega Sustenna**

Dosage	Units Requested	Frequency	Total Units
39mg	39	Q 1 month	_____
117mg	117	Q 1 month	_____
156mg	156	Q 1 month	_____
234mg	234	Q 1 month	_____
390mg*	390	Initial dose	_____

Other: _____

*(Given in 2 separate injections of 234mg and 156mg)

Circle All Applicable Criteria Specific to this Request For Invega Sustenna:

A. Patient is 18 years or older;
B. Patient has a diagnosis of schizophrenia using DSM-IV criteria;
C. Patient is under the care of or in consultation with a psychiatrist;
D. Patient has tried and failed, was intolerant to, or there was contraindication for, at least 2 atypical antipsychotic medications, one of which was Risperidone or Risperdal Consta. Reason for discontinuing: _____
E. Patient has a history of noncompliance or is unable to swallow oral dosage forms of antipsychotic medications;
F. Patient has a documented response to Invega, but been noncompliant on the oral form of this medication;
G. Patient has been prescribed Invega Sustenna prior to arrival to my practice and is stable on the medication.

☐ **J2358 Zyprexa Relprevv**

Dosage	Units Requested	Frequency	Total Units
150mg	150	Q2 weeks	_____
210mg	210	Q2 weeks	_____
300mg	300	Q2 weeks	_____
300mg	300	Q4 weeks	_____
405mg	405	Q4 weeks	_____

Other: _____

Circle All Applicable Criteria Specific to this Request For Zyprexa Relprevv:

H. Patient is 18 years or older;
I. Patient has a diagnosis of schizophrenia using DSM-IV criteria;
J. Patient is under the care of or in consultation with a psychiatrist;
K. Patient has tried and failed, was intolerant to, or there was contraindication for, at least 2 atypical antipsychotic medications, one of which was Risperidone or Risperdal Consta. Reason for discontinuing: _____
L. Patient has a history of noncompliance or is unable to swallow oral dosage forms of antipsychotic medications;
M. Patient has a documented response to Invega, but been noncompliant on the oral form of this medication;
N. Patient has been prescribed Zyprexa Relprevv prior to arrival to my practice and is stable on the medication.

If you are a non-participating provider, please indicate which other medication code you are requesting:

Medication Code:	J3486	J0400	J3230	J2680	J0780	J1630	J1631	J2060	J3360
Dosage									
Units Requested									
Frequency									
Total Units									

Please describe the cross titration schedule and intended final drug regimen should the requested medication be approved: _____

_____

_____

_____
Physician Signature Date