



STATE OF MARYLAND

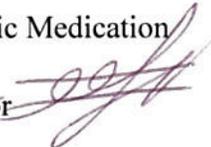
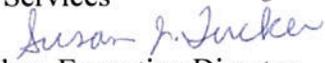
DHMH

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

**Maryland Medical Assistance Program**  
**Pharmacy Transmittal No. 197**  
**July 31, 2012**

**TO:** Prescribers of Antipsychotic Medication

**FROM:** Athos Alexandrou, Director   
Pharmacy Services  
Susan Tucker, Executive Director   
Office of Health Services

**NOTE:** Please ensure that appropriate staff members in your organizations are informed of the contents of this transmittal.

**RE:** Changes to the Prior Authorization Form for Preferred Tier 2 and Non-preferred Antipsychotic Medications

Starting on August 20, 2012, the Maryland Medicaid Pharmacy Program (MMPP) is changing the prior authorization form and criteria used for approval of preferred tier 2 and non-preferred antipsychotic medications. A copy of the new form is attached. You can also find an electronic version of the form on the MMPP website at:

<http://mmcp.dhmh.maryland.gov/pap/SitePages/Preferred%20Drug%20List.aspx>.

The clinical criteria are also listed on the MMPP website at:

<http://mmcp.dhmh.maryland.gov/pap/SitePages/Clinical%20Criteria.aspx> .

You are receiving this transmittal because in the past 12 months, you have prescribed an antipsychotic medication to one or more Maryland Medicaid patients.

Questions concerning this transmittal should be directed to the Maryland Medicaid Pharmacy Program at (410) 767-1455.

Attachment

# Maryland Medicaid Pharmacy Program

Tel: 1-800-932-3918

Fax: 1-866-440-9345

## Tier II and Non-Preferred Antipsychotic Prior Authorization form

<b><u>Prescriber Information</u></b>
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Prescriber Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Specialty: \_\_\_\_\_

Tel: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

<b><u>Patient Information</u></b>
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Patient Name: \_\_\_\_\_ Patient MA#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

DOB (MM/DD/YY): \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Height (inches): \_\_\_\_\_ Weight (pounds): \_\_\_\_\_

<b><u>Diagnosis (Current DSM Diagnosis) Please check all that apply</u></b>				
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ADHD	Anti-social or Borderline Person Disorder	Asperger's or PDDNOS	Autistic Disorder	Bipolar Disorder
Conduct or Oppos. Def. Disorder	Dementia	Generalized Anxiety Disorder	Major Depressive Disorder	Mental Retardation
Obsessive Compulsive Disorder	Panic Disorder	Psychotic Disorder - Not Schiz. (specify): _____	PSTD	Schizoaffective Disorder
Schizophrenia	Social Phobia	Tourette's Disorder	Other (specify): _____	

**Target Symptoms (check all target symptoms for which drug is being prescribed)**

aggression	delusions	depression	hallucinations	irritability
mania	mood lability	self-injurious behavior	insomnia	other (specify): _____

**Antipsychotic for which authorization is being sought: (Check)**

<u>Abilify</u>	<u>Fanapt</u>	<u>Fazaclor</u>	<u>Invega</u>	<u>Invega Sustenna</u>
<u>Latuda</u>	<u>Olanzapine IM</u>	<u>Olanzapine</u>	<u>Saphris</u>	<u>Seroquel XR</u>
<u>Symbyax</u>	<u>Ziprasidone</u>	<u>Zyprexa Relprevv</u>		

**Maryland Medicaid Pharmacy Program**

**Tel: 1-800-932-3918**

**Fax: 1-866-440-9345**

**Tier II and Non-Preferred Antipsychotic Prior Authorization form**

**Dosage Form: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_**

**Dosage Form: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency: \_\_\_\_\_ Quantity: \_\_\_\_\_**

**Was the patient discharged from the inpatient setting on requested medication? Yes No**

**Does the patient have a condition that prevents the use of the preferred medication? Yes No**

**If yes, please specify: \_\_\_\_\_**

**Is there a drug-drug interaction between another medication and the preferred medication? Yes No**

**If yes, please specify: \_\_\_\_\_**

**Has the patient experienced treatment failure with other medications? Yes No**

**If yes, please list which medications the patient has tried:**

<u>Medication Name</u>	<u>Strength/Frequency</u>	<u>Date Used</u>	<u>Compliance (at least 6 days/wk)</u>	<u>Reason for Discontinuation</u>
			<u>Yes</u> <u>No</u>	
			<u>Yes</u> <u>No</u>	
			<u>Yes</u> <u>No</u>	