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NC Medicaid
ASAP: Adult Safety with Antipsychotic Prescribing for Beneficiaries 18 Years of Age and Older Form

Fax this form to 866-422-8981

Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). Information contained in this form is Protected Health Information under HIPAA.

REQUESTER INFORMATION

Requester Last Name: _____

Requester First Name: _____

Requester Phone: _____ Requester Fax: _____ Date: _____

BENEFICIARY INFORMATION

Beneficiary Last Name: _____

Beneficiary First Name: _____

Beneficiary ID: _____ Date of Birth: _____ Beneficiary Phone: _____

Sex: ☐ Male ☐ Female

Allergies: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Specialty: _____ Prescriber NPI: _____

Prescriber Phone: _____ Prescriber Fax: _____

DRUG INFORMATION

Drug Name: _____ Drug Strength: _____

Drug Form: _____ Dosing Frequency: _____

Quantity: _____ Length of Therapy: _____

Dose Instructions: _____

Beneficiary's Full Name: _____

CLINICAL INFORMATION

Criteria for non-preferred medications:

1. ☐ The beneficiary has failed 1 preferred drug.

   List preferred drugs failed: _____

   ☐ Allergic Reaction ☐ Drug-to-drug interaction

   Describe reaction: _____

2. ☐ The beneficiary has had a previous episode of an unacceptable side effect or therapeutic failure.

   Please provide clinical information:

   _____

3. ☐ The beneficiary has a clinical contraindication, co-morbidity, or unique circumstance as a contraindication to preferred drug(s).

   Please provide clinical information:

   _____

4. ☐ The beneficiary has age specific indications.

   Please give beneficiary's age and explain:

   _____

5. ☐ The beneficiary has a unique clinical indication supported by FDA approval or peer reviewed literature.

   Please explain and provide a general reference:

   _____

6. ☐ There is unacceptable risk associated with therapeutic change.

   Please explain:

   _____

Criteria for ALL medications:

7. What is the beneficiary's primary psychiatric diagnosis?

   ☐ Attention deficit-hyperactivity disorder

   ☐ Bipolar disorder

   ☐ Disruptive behavior disorder

   ☐ Mood disorder not otherwise specified

   ☐ Any pervasive development disorder

Beneficiary's Full Name: _____

- ☐ Post-traumatic stress disorder
- ☐ Schizophrenia
- ☐ Schizoaffective disorder
- ☐ Tourette's syndrome
- ☐ Other: _____

8. What is the beneficiary's target symptom?

☐ Aggression	☐ Impulsivity
☐ Inattentiveness	☐ Irritability
☐ Mania	☐ Oppositional
☐ Psychosis	☐ Other: _____

9. Has the beneficiary and/or guardian been informed of the potential metabolic adverse effects with this medication, and do they wish to continue receiving this therapy?

   ☐ Yes ☐ No

10. Has the beneficiary and/or guardian been informed of the potential neurologic adverse effects with this medication, and do they wish to continue receiving this therapy?

    ☐ Yes ☐ No

☐ Attachments

By signing this request, the prescriber attests that the information provided herein is true and accurate to the best of their knowledge.

Prescriber Signature: _____ **Date**: _____

Mail requests to:

Prime Therapeutics Management Prior Authorization Program
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 844-620-6116

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