magnolia health
Mississippi Children's Health Insurance Program

Cenpatico
Improving Lives

Request for Prior Authorization Form
Injectable Antipsychotics

Fax completed form to Cenpatico at **866-694-3649**. Upon receipt of all necessary information Cenpatico will contact you by fax or phone within two business days after receipt. **If you are a participating provider, no authorization is required for Haldol, Haldol-D, Prolixin, Prolixin-D or Geodon.**

Date: _____

MEMBER INFORMATION	PROVIDER INFORMATION
NAME	NAME
DATE OF BIRTH	TAX ID
MEMBER ID	PROVIDER NPI
HEALTH PLAN	PHONE FAX

Start Date Needed for this Authorization: _____

PRIMARY DIAGNOSIS

Axis I: _____

OTHER DIAGNOSES

Axis II: _____

Axis III: _____

Please Check: ☐ New Medication Request **OR** ☐ Continuing Medication Request

CHECK ALL APPLICABLE CRITERIA SPECIFIC TO THIS MEDICATION REQUEST:

These criteria apply to all injectable medications. Additional medication specific criteria are listed under each medication:

☐ **A.** Patient is under a court order for outpatient treatment and medications. Date of court order (please also attach the order): _____

☐ **B.** Patient is at least 18 years of age.

☐ **C.** The medication is being prescribed by a psychiatrist (MD/DO), Nurse Practitioner (ARNP, NP), Mental Health Nurse Practitioner (MHNP), or Clinical Nurse Specialist (CNS).

☐ **D.** Patient has been diagnosed with one of the disorders listed in the DSM-IV under "Schizophrenia and other Psychotic Disorders," or is being treated for Bipolar Disorder with a history of medication non-compliance.

☐ **E.** If the member is currently on an oral atypical antipsychotic, the provider will discontinue it within one month of the initiation of the long acting injectable atypical antipsychotic; or, if the member still requires an oral atypical antipsychotic, there has been an attempt to reduce or discontinue it.

☐ **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: _____

CHECK ALL APPLICABLE CRITERIA SPECIFIC TO THIS REQUEST FOR RISPERDAL CONSTA:

☐ **F.** Patient had a documented response to Risperdal, but was noncompliant on the oral form of this medication, which resulted in inpatient hospitalization(s).

☐ **G.** Dosage planned is 50 mg **or less** Q2 weeks.

☐ **H.** For continuing requests, the member is currently being prescribed requested mediation, is stable and has been compliant with treatment; or, the patient was previously prescribed Risperdal Consta by another provider and was stable on the medication when he/she began receiving services from your practice. Please include information on the previous provider, as available:

☐ **I.** For new requests, where the member is titrating from oral to injectable medication, describe the cross titration schedule and intended final drug regimen.

☐ **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)

CHECK ALL APPLICABLE CRITERIA SPECIFIC TO THIS REQUEST FOR INVEGA SUSTENNA:

☐ **F.** The member has had a prior unsuccessful trial of Risperdal Consta. The provider also indicates whether it is clinically contraindicated for this patient due to hypersensitivity, adverse effects, clinical contraindications or ineffective/sub-optimal response to maximized dosing.

☐ **G.** Patient had a documented response to Invega, but was noncompliant on the oral form of this medication, which resulted in inpatient hospitalization(s).

☐ **H.** For continuing requests, the member is currently being prescribed requested mediation, is stable, and has been compliant with treatment; or, the patient was previously prescribed Invega Sustenna by another provider, and was stable on the medication when he/she began receiving services from your practice. Please include information on the previous provider, as available:

☐ **I.** For new requests, where the member is titrating from oral to injectable medication, describe the cross titration schedule and intended final drug regimen.

☐ **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: _____

CHECK ALL APPLICABLE CRITERIA SPECIFIC TO THIS REQUEST FOR ZYPREXA RELPREVV:

☐ **F.** The member has had a prior unsuccessful trial of Risperdal Consta. The provider also indicates whether it is clinically contraindicated for this patient due to hypersensitivity, adverse effects, clinical contraindications or ineffective/sub-optimal response to maximized dosing.

☐ **G.** Patient had a documented response to Zyprexa, but was noncompliant on the oral form of this medication, which resulted in inpatient hospitalization(s).

☐ **H.** For continuing requests, the member is currently being prescribed requested mediation, is stable, and has been compliant with treatment; or, the patient was previously prescribed Zyprexa Relprevv by another provider, and was stable on the medication when he/she began receiving services from your practice. Please include information on the previous provider, as available:

☐ **I.** For new requests, where the member is titrating from oral to injectable medication, describe the cross titration schedule and intended final drug regimen.

☐ **J.** Patients who receive Zyprexa Relprevv are at risk for severe sedation (including coma) and/or delirium after each injection (Post-Injection Delirium/Sedation Syndrome) and must be observed for at least 3 hours in a registered facility with ready access to emergency response services. Please describe how these requirements will be met:

☐ **K.** Provider has identified which one of 3 possible medication regimens will be used for this patient:

- ☐ 1. Oral dose 10 mg/day: 210 IM q2wk or 405 mg IM q4wk for 1st 8 weeks, then 150 mg q2wk or 300 mg q4wk
- ☐ 2. Oral dose 15 mg/day: 300 mg IM q2wk for 1st 8 weeks, then 210 mg q2wk or 405 mg q4wk
- ☐ 3. Oral dose 20 mg/day: 300 mg IM q2wk for 1st 8 weeks; continue with 300 mg q2wk thereafter

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☐ **J0401 Abilify Maintena**

Dosage	Units Requested	Frequency	Total Units
300mg	300	Q4 weeks	
400mg	400	Q4 weeks	

Other: _____

Check All Applicable Criteria Specific to this Request For Abilify Maintena:

☐ **F.** The member has had a prior unsuccessful trial of Risperdal Consta. Or, the member has had a prior unsuccessful trial of oral Risperdal, making it inappropriate to attempt Risperdal Consta. The provider indicates whether it is clinically contraindicated for this member due to hypersensitivity, adverse effects, clinical contraindications, or ineffective/sub-optimal response to maximized dosing.

☐ **G.** Member had a documented response to Abilify but was noncompliant on the oral form of this medication, which resulted in inpatient hospitalization(s).

☐ **H.** For continuing requests, the member was prescribed the medication by this provider, is currently stable, and has been compliant with treatment. Or, the member was prescribed Abilify Maintena by another provider, and was stable on the medication when he/she began receiving services from the most recent provider; the current request includes the information about the previous provider if available.

☐ **I.** For new requests, where the member is receiving this injectable for the first time, and where the member is titrating from oral to injectable medication, the provider has described the cross titration schedule and intended final drug regimen.

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									

Physician Signature

Date