SUBMIT TO
Utilization Management Department
Phone: 1.866.912.6285 Fax: 1.833.840.0479

magnolia health

INJECTABLE ANTIPSYCHOTICS AUTHORIZATION FORM

Fax completed form to Cepatico at 866.694.3649. Upon receipt of all necessary information Cenpatico will contact you by fax or phone within two business dates after receipt**. If you are a participating provider, no authorization is required for Haldol, Haldol-D, Prolixin-D or Geodon.**

Date_____

MEMBER INFORMATION

Name_____

DOB _____

Member ID #_____

Health Plan _____

Start Date Needed for this Authorization: _____

PROVIDER INFORMATION

Provider Name (print) _____

Provider/Agency Tax ID #_____

Provider/Agency NPI Sub Provider #_____

Phone _____ Fax _____

CURRENT ICD DIAGNOSIS

Primary_____

Secondary _____

Tertiary_____

Additional _____

Additional_____

☐ 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 to criteria are listed under each medication:

☐ A. Member is under a court order for outpatient treatment and medications. Date of court order (Please attach the Order): _____.

☐ B. Member is at least 18 years of age.

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

☐ D. Member 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	Q2 weeks	

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

☐ F. Member had a documented response to Risperdal, but was non-compliant to the oral form of this medication, which resulted in inpatient hospitalization(s).

☐ G. Dosage planned is 50 mg or less Q 2 weeks.

☐ H. For continuing requests, the member is currently being prescribed requested medication, is stable and has been compliant with treatment; or, the patient was previously prescribed Risperdal Consta by another provider and was stable.

☐ 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 Required	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	

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

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

☐ B. Member had a documented response to Invega, but was non-compliant on the oral form of this medication, which resulted in inpatient hospitalization.

☐ C. For continuing requests, the member is currently being prescibed requested medication, 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 availble.

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

J2426 INVEGA TRINZA

Dosage	**Units Requested**	**Frequency**	**Total Units**
273mg	273	Once every 3 months	
410mg	410	Once every 3 months	
546mg	546	Once every 3 months	
819mg	819	Once every 3 months	

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

☐ A. The member has a documented diagnosis of schizophrenia and has been shown to have been adequately treated with Invega Sustenna for at least 4 months or more than 4 months.

☐ B. Member has a documented response to Invega and has demonstrated non-compliance on the oral form of this medication. The following contraindications and reasons to discontinue Invega Trinza have been reviewed and accepted by the provider:

- Dementia-related psychosis
- Known hypersensitivity to paliperidone, risperidone, or to any excipients in the formulation
- If > 9 months have elapsed since the last Invega Trinza injection, the patient should re-establish treatment with Invega Sustenna x four months before reinitiating Invega Trinza therapy

☐ C. For continuing requests, the member is currently being prescribed requested medication, 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.

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

J3490 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	

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

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

☐ B. Patient had a documented response to Invega, but was non-compliant on the oral form of this medication, which resulted in inpatient hospitalization.

☐ C. For continuing requests, the member is currenlty being prescribed requested medication, 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.

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

☐ E. Patients who receive Zyprexa Relprevv are at risk for severe sediation (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 repsonse services. Please describe how these requirements will be met:

☐ F. 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 q2w or 405 mg q4wk.
- ☐ 3. Oral dose 20 mg/day: 300 mg IM q2wk for 1st 8 weeks, continue with 300 mg q2wk thereafter.

J0401 ABILIFY MAINTENA

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

CHECK ALL APPLICABLE CRITERIA SPECIFIC TO THIS REQUEST FOR Abilify Maintena:

☐ A. 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.

☐ B. Member has a documented response to Abilify but was non-compliant to the oral form of the medication, which resulted in inpatient hospitalization(s).

☐ C. 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.

☐ D. 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.

C9470 ARISTADA

Dosage	Units Requested	Frequency	Total Units
441mg	441	Q4 weeks	
662mg	662	Q4 weeks	
882mg	882	Q4 weeks	

CHECK ALL APPLICABLE CRITERIA SPECIFIC TO THIS REQUEST FOR Abilify Aristada

☐ A. For initial (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 must describe the cross titration schedule and intended final drug regimen. Also, the member must have been diagnosed by a psychiatrist with schizophrenia, and has had a prior successful trial of Abilify Maintena. 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.

☐ B. Member has a documented response to Abilify but was non-compliant on the oral form of the medication, which resulted in inpatient hospitalization (s).

☐ C. Therapeutic plan includes an initial 21 days of concomitantly administered oral aripiprazole therapy with Aristada; no contraindications to Aristada such as: dementia-related psychosis or known hypersensitivity reaction to aripiprazole.

☐ D. 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 Aristada by another provider, and was stable on the medication when he/ she began receiving services from the most recent provider; the current request includes information about the previous provider if available. The member must also meet the following criteria for continuing requests: documented adherence to Aristada; demonstrated a therapeutic response; and 1. If currently taking 441 mg of Aristada and > 6 weeks have elapsed since the last injection, the plan includes concomitant oral aripiprazole; Or 2. If currently taking 662 mg or 882 mg of Aristada and > 8 weeks have elapsed since the last injection, the plan includes concomitant oral aripiprazole; 3. No contraindications to or reasons to discontinue Aristada

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

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

Physician Signature _____ Physician Printed Name _____ Date _____

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