Print Form Reset Form

FLORIDA MEDICAID PRIOR AUTHORIZATION

ADULT ANTIPSYCHOTIC HIGH DOSE

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

Prescriber Phone Number -

Prescriber Fax Number -

Drug, Dose and Frequency: _____

Diagnosis: _____

Previous Antipsychotic Trials (include drug, maximum dose, duration, and trial dates):

1. _____
2. _____
3. _____

Rationale for high dose antipsychotic (check all that apply):

- ☐ Failure to respond to clozapine
- ☐ Failure to respond to clozapine with augmentation
- ☐ Failure to tolerate clozapine
- ☐ During the switch of one antipsychotic to another
- ☐ As a temporary measure during an acute episode
- ☐ Other: _____

Please provide the monitoring plan (including tapering schedule) in the space provided below.

Prescriber's Signature _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), a copy of the original prescription, and the most recent copies of related labs. **The provider must retain copies of all documentation for five years.**

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727