



**\*NOTE: Section A or B must be completed.\***

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**A. The member has been established on the requested medication**

- How long has the member been taking the requested medication?  <2 weeks  ≥2 weeks
- Has the member shown improvement in symptoms while on the requested medication?  Yes  No  
If yes, please check one or more boxes below for areas of improvement:
 

<input type="checkbox"/> delusions	<input type="checkbox"/> excitement	<input type="checkbox"/> conceptual disorganization
<input type="checkbox"/> grandiosity	<input type="checkbox"/> hostility	<input type="checkbox"/> hallucinatory behavior
<input type="checkbox"/> suspiciousness/persecution	<input type="checkbox"/> blunted affect	<input type="checkbox"/> emotional withdrawal
<input type="checkbox"/> passive/apathetic social withdrawal		<input type="checkbox"/> poor rapport
<input type="checkbox"/> difficulty in abstract thinking	<input type="checkbox"/> lack of spontaneity and flow of conversation	
<input type="checkbox"/> stereotyped thinking	<input type="checkbox"/> suicidal thoughts	<input type="checkbox"/> depressive symptoms
<input type="checkbox"/> other _____		

**B. The member has never taken the requested medication**

- Which preferred medication(s) has the member tried? (check all that apply)
 

<input type="checkbox"/> Abilify Dates: _____	<input type="checkbox"/> Latuda Dates: _____	<input type="checkbox"/> Olanzapine Dates: _____	<input type="checkbox"/> Risperidone Dates: _____
<input type="checkbox"/> Quetiapine IR Dates: _____	<input type="checkbox"/> Ziprasidone Dates: _____	<input type="checkbox"/> None	
- Reason preferred agents are not appropriate for this member. (complete for each applicable drug in the following table)

Drug	Reason inappropriate choice for member
Abilify	
Latuda	
Olanzapine	
Risperidone	
Quetiapine IR	
Ziprasidone	

- For Abilify, Seroquel XR, Symbyax (for major depressive disorder only): Reason antidepressant monotherapy is not adequate for this member. (complete for each drug/class in the following table)

Drug	List medication name, response, and dates of therapy
SNRIs (desvenlafaxine [Pristiq], duloxetine [Cymbalta], venlafaxine [Effexor/XR])	
SSRIs (citalopram [Celexa], escitalopram [Lexapro], fluvoxamine [Luvox], fluoxetine [Prozac], paroxetine [Paxil], or sertraline [Zoloft])	
Other Antidepressants (bupropion, mirtazapine, trazodone; list may not be all inclusive)	

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**C. An orally disintegrating dosage formulation is being requested.**

- What prevents the member from taking the regular oral dosage form?
 

<input type="checkbox"/> Dysphagia	<input type="checkbox"/> Compliance monitoring required
<input type="checkbox"/> Other (specify): _____	

**D. Risperdal Consta, Invega Sustenna, or Zyprexa Relprevv is being requested.**

- Has the member tried oral risperidone or oral Invega (if Risperdal Consta is being requested), oral Invega, oral risperidone, or Risperdal Consta (if Invega Sustenna is being requested), or oral Zyprexa (if Zyprexa Relprevv is being requested) or does the member have a history of noncompliance with oral medications and is unable to receive a trial of the appropriate oral atypical antipsychotic before starting long-acting therapy with injection or is the member unable to swallow or use orally disintegrating tablets?
 

<input type="checkbox"/> Yes	Date of last therapy: _____	<input type="checkbox"/> No
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- Is the prescribing physician a psychiatrist or has a psychiatrist been consulted?
 

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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- Where will the medication be administered?
 

<input type="checkbox"/> Home health or other outpatient pharmacy setting by a trained health care professional
<input type="checkbox"/> Long-term care facility

CSB (Community Service Board health center)

Physician's office or clinic\*\*

Other (specify): \_\_\_\_\_

\*\* If you are requesting for authorization for administration in a physician's office or clinic other than a CSB, please go to the Registered User portion of the Georgia Health Partnership website at [www.mmis.georgia.gov/portal](http://www.mmis.georgia.gov/portal) to request a PA from Physician Services.

**Section E: In the space below, please provide letter of medical necessity and any additional information you deem clinically relevant in evaluating the prior authorization request.**

**Physician Signature:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **Phone:** \_\_\_\_\_