



Multiple Antipsychotics Override Request
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this
Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that members receiving a prescription for multiple antipsychotics to meet specific clinical criteria for coverage. Criteria for coverage for multiple antipsychotics can be found in the following location:

- The Preferred Drug List (PDL) available at www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Prescriber Name		Specialist involved in therapy (if not treating prescriber)			
Prescriber NPI		Telephone Number		Fax Number	
Address		City		State	Zip Code
Requested Drug and Dosage:			Diagnosis for this request:		
What non-antipsychotic mood stabilizers have been trialed or ruled out for treatment and justification for that decision?					
Is clozapine an option for duplicate antipsychotic for unresolved symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is hydroxyzine an option for sleep and/or anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<input type="checkbox"/> I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.					
Prescriber (or Staff) / Pharmacy Signature**				Date	
**: By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.					

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #		

Multiple Antipsychotic Override Requests

When are the breakthrough symptoms occurring (e.g. timeframe from injection)? Any other contributing factors (non-pharmacological) and how addressed, if so?

At what point, would the first medication be considered a failure / other treatment would be considered?

What is the anticipated benefit of another medication (vs. increasing dose or switching medication)?

Why is one antipsychotic unable to be maximized to treat all targeted symptoms?

What symptoms are being targeted with each antipsychotic?

For injections:

What would be the tapering goal for oral antipsychotic if symptoms abate as long-term supplemental use of oral with injectable safety/efficacy data lacking?

What is the site of administration?

For duplicate quetiapine requests:

If sedation/anxiety is part of a reason for the quetiapine treatment, which medications have been trialed?

- A hydroxyzine trial is required for sedation/anxiety
- Primary use for insomnia will not be approved