GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM *(form effective 01/03/2022)*

Prior authorization guidelines for **Antipsychotics** and **Quantity Limits/Daily Dose Limits** guidelines are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Phone of office contact:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form (tablet, solution, etc.):	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Diagnosis code (*required*):	

REQUEST for a NON-PREFERRED drug	
Has the beneficiary taken the requested non-preferred antipsychotic in the past 90 days?	☐Yes – *Submit documentation.* ☐No
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred medications in this class? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐Yes – *Submit documentation of therapeutic failure.* ☐No
REQUEST for a beneficiary LESS THAN 18 YEARS of age	
Is this request for a dose increase of a previously approved medication?	☐Yes – *Submit recent chart documentation supporting the increased dose.* ☐No
Is the requested agent prescribed by or in consultation with one of the following physician specialists? ☐child development pediatrician ☐general psychiatrist (only if beneficiary is ≥ 14 years of age) ☐child & adolescent psychiatrist ☐pediatric neurologist	☐Yes ☐No *Submit documentation of consultation, if applicable.*
Does the beneficiary have severe behavioral problems related to a psychotic or neuro-developmental disorder (e.g., autism spectrum disorder, bipolar disease, conduct disorder, intellectual disability, schizophrenia, tic disorder [including Tourette's syndrome], transient encephalopathy)?	☐Yes ☐No *Submit medical record documentation.*
Has the beneficiary tried non-drug therapies (e.g., evidence-based behavioral, cognitive, and family-based therapies)?	☐Yes ☐No *Submit documentation of therapies tried.*
Did the beneficiary have the following baseline and/or follow-up monitoring? *Check all that apply and submit documentation for each item.* ☐BMI (or weight/height) ☐blood pressure ☐fasting glucose level ☐fasting lipid panel ☐presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)	

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

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Prescriber Signature:	**Date**: