ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM

(form effective 1/5/2026)

Keystone First | PerformRx℠ Next Generation Pharmacy Benefits

Fax to PerformRx℠ at **1-866-497-1387**, or to speak to a representative, call **1-800-588-6767**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total pages:	Office contact/phone:	LTC facility contact/phone:

PATIENT INFORMATION

Patient name:		Patient ID#:	DOB:
Street address:	Apt #:	City/state/zip:	

PRESCRIBER INFORMATION

Prescriber name:		
Specialty:	NPI:	State license #:
Street address:	Suite #:	City/state/zip:
Phone:	Fax:	

MEDICATION REQUESTED

Preferred Agents

Non-Injectable

☐ Aripiprazole Tablet
☐ Clozapine Tablet
☐ Equetro (carbamazepine) Capsule
☐ Fluphenazine Oral Concentrate Solution
☐ Fluphenazine Tablet
☐ Haloperidol Tablet
☐ Haloperidol Lactate Oral Concentrate Solution
☐ Loxapine Capsule
☐ Lurasidone Tablet
☐ Olanzapine Tablet
☐ Paliperidone ER Tablet
☐ Perphenazine Tablet
☐ Quetiapine Tablet
☐ Quetiapine ER Tablet
☐ Risperidone Solution
☐ Risperidone Tablet
☐ Trifluoperazine Tablet
☐ Ziprasidone Capsule

Injectable

☐ Abilify Asimtufii (aripiprazole)
☐ Abilify Maintena (aripiprazole)
☐ Aristada ER (aripiprazole lauroxil)
☐ Aristada Initio (aripiprazole lauroxil)
☐ Fluphenazine Decanoate Vial
☐ Haloperidol Decanoate Ampule
☐ Haloperidol Decanoate Vial
☐ Haloperidol Lactate Syringe
☐ Haloperidol Lactate Vial
☐ Invega Hafyera (paliperidone)
☐ Invega Sustenna (paliperidone)
☐ Invega Trinza (paliperidone)
☐ Perseris ER (risperidone)
☐ Risperdal Consta (risperidone)
☐ Risperidone ER Vial
☐ Uzedy ER (risperidone)

Strength:	Dosage form:	Directions:
Diagnosis:		

Non-Preferred Agents

Non-Injectable

☐ Abilify (aripiprazole) Tablet
☐ Adasuve (loxapine) Inhalation Powder
☐ Aripiprazole ODT
☐ Aripiprazole Solution
☐ Asenapine SL Tablet
☐ Caplyta (lumateperone) Capsule
☐ Chlorpromazine Concentrate Solution
☐ Chlorpromazine Tablet
☐ Clozapine ODT
☐ Clozaril (clozapine) Tablet
☐ Cobenfy (xanomeline-trospium) Capsule
☐ Fanapt (iloperidone) Tablet
☐ Fluphenazine Elixir
☐ Geodon (ziprasidone) Capsule
☐ Invega ER (paliperidone) Tablet
☐ Latuda (lurasidone) Tablet
☐ Lybalvi (olanzapine/samidorphan) Tablet
☐ Molindone Tablet
☐ Nuplazid (pimavanserin) Capsule
☐ Nuplazid (pimavanserin) Tablet
☐ Olanzapine ODT
☐ Olanzapine-Fluoxetine Capsule
☐ Opipza (aripiprazole) Film
☐ Perphenazine-Amitriptyline Tablet
☐ Pimozide Tablet
☐ Rexulti (brexpiprazole) Tablet
☐ Risperdal (risperidone) Solution
☐ Risperdal (risperidone) Tablet
☐ Risperidone ODT
☐ Saphris SL (asenapine) Tablet
☐ Secuado (asenapine) Patch
☐ Seroquel (quetiapine) Tablet
☐ Seroquel XR (quetiapine) Tablet
☐ Thioridazine Tablet
☐ Thiothixene Capsule
☐ Versacloz (clozapine) Suspension
☐ Vraylar (cariprazine) Capsule
☐ Zyprexa (olanzapine) Tablet
☐ Zyprexa (olanzapine) Zydis

Injectable

☐ Chlorpromazine Ampule
☐ Chlorpromazine Vial
☐ Fluphenazine HCl Vial
☐ Geodon (ziprasidone) Vial
☐ Haldol Decanoate (haloperidol) Ampule
☐ Olanzapine Vial
☐ Ziprasidone Vial
☐ Zyprexa Relprevv (olanzapine)
☐ Zyprexa (olanzapine) Vial

Strength:	Dosage form:	Directions:
Diagnosis:		

PHARMACY INFORMATION (Prescriber to identify the pharmacy that is to dispense the medication):

Deliver to: ☐ Patient's Home ☐ Physician's Office ☐ Patient's Preferred Pharmacy Name:

Pharmacy Phone #:	Pharmacy Fax #:

☐ I acknowledge that the patient agrees with the pharmacy chosen for delivery of this medication.

REQUEST FOR A NON-PREFERRED AGENT

1. Has the patient taken the requested non-preferred antipsychotic in the past 90 days? ☐ Yes – *Submit documentation.* ☐ No
2. Has the patient tried and failed the preferred medications (listed above)? ☐ Yes – List medications tried: ☐ No
3. Does the patient have a contraindication or intolerance to the preferred medications? ☐ Yes – *Submit documentation of contraindication/intolerance.* ☐ No
4. For request of Opipza (aripiprazole) film: Does the patient have a contraindication or intolerance to aripiprazole ODT that is not expected to occur with Opipza film? ☐ Yes – *Submit documentation of contraindication/intolerance.* ☐ No

REQUEST FOR A PATIENT LESS THAN 18 YEARS OF AGE

5. For renewal requests, has the patient had improvement in target symptoms with use of this medication? ☐ Yes ☐ No
6. Is this request for a dose increase of a previously approved medication or request over the plan limits? ☐ Yes – *Submit recent chart documentation and/or treatment guidelines supporting the requested dose.* ☐ No
7. For renewal requests, is there a plan for taper/discontinuation or rationale for continued use of requested drug ? ☐ Yes Submit supporting documentation. ☐ No
8. Is the requested agent prescribed by, or in consultation with, one of the following physician specialists? ☐ Yes ☐ No *Submit documentation of consultation, if applicable.*
   ☐ child development pediatrician ☐ child & adolescent psychiatrist ☐ general psychiatrist (only if patient is ≥ 14 years of age) ☐ pediatric neurologist
9. Does the patient have severe symptoms related to a psychotic or neuro-developmental disorder? ☐ Yes – *Submit medical record documentation.* ☐ No
10. Has chart documented evidence of comprehensive evaluation and plan of care that includes non-drug therapies? ☐ Yes – *Submit medical record documentation.* ☐ No
11. For a drug with risk of metabolic changes: Has the patient had the following baseline and/or follow-up monitoring? Check all that apply.
    ☐ BMI and/or weight (for follow-up monitoring this must be done quarterly) ☐ blood pressure ☐ fasting blood glucose or hemoglobin a1c ☐ fasting lipid panel
    ☐ presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)
    Submit documentation of all monitoring/test results and dates.

REQUEST FOR THERAPEUTIC DUPLICATION OF AN ATYPICAL OR TYPICAL ANTIPSYCHOTIC

12. Does the patient have a medical reason for concomitant use of the requested medications? ☐ Yes – *Submit documentation of treatment guidelines supporting concomitant use.* ☐ No
13. Is this request for a drug that is being titrated to, or tapered from, a drug in the same class? ☐ Yes ☐ No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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