



**ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM** (effective 1/5/2026)

Prior authorization guidelines for **Antipsychotics** and **Quantity Limits/Daily Dose Limits** guidelines are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services>.

<input type="checkbox"/> New request <input type="checkbox"/> 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:		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):	
Is the beneficiary currently being treated with the requested medication?	<input type="checkbox"/> Yes – date of last dose: _____ Submit documentation. <input type="checkbox"/> No		

**Complete all sections that apply to the beneficiary and this request.**  
**Check all that apply and submit documentation for each item.**

**INITIAL requests**

- For a NON-PREFERRED Antipsychotic:**
  - The beneficiary tried and failed or has a contraindication or an intolerance (such as diabetes, obesity, etc.) to the preferred Antipsychotics (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)
  - If the request is for **Opipza (aripiprazole) film**, the beneficiary has a contraindication or intolerance to aripiprazole ODT that would not be expected to occur with Opipza film
- For an Antipsychotic for a child UNDER THE AGE OF 18 YEARS:**
  - Is prescribed the Antipsychotic by or in consultation with one of the following specialists:
    - a child development pediatrician       a general psychiatrist (only if beneficiary is ≥14 years of age)
    - a child & adolescent psychiatrist       a pediatric neurologist
  - Has severe symptoms related to psychotic or neurodevelopmental disorders such as seen in the following diagnoses:
    - autism spectrum disorder       mood disorders with psychotic features
    - bipolar disorder       schizophrenia & schizophrenia-related disorders
    - conduct disorder       tic disorder (including Tourette's syndrome)
    - intellectual disability       transient encephalopathy



- Has chart documented evidence of a comprehensive evaluation
- Has a documented plan of care that includes non-pharmacologic therapies (eg, evidence-based behavioral, cognitive, and family-based therapies) when indicated according to national treatment guidelines
- For an Antipsychotic with risk of metabolic changes:** Has documented baseline monitoring of the following:
  - blood pressure
  - extrapyramidal symptoms using Abnormal Involuntary Movement Scale (AIMS)
  - fasting lipid panel
  - weight or BMI
  - fasting glucose or HbA1c

**RENEWAL requests for a child UNDER THE AGE OF 18 YEARS**

**1. For an Antipsychotic for a child UNDER THE AGE OF 18 YEARS:**

- Has documented improvement in target symptoms
- For an Antipsychotic with risk of metabolic changes:** Has documented quarterly monitoring of weight or BMI
- For an Antipsychotic with risk of metabolic changes:** Has documented monitoring of the following after the first 3 months of therapy and annually thereafter:
  - blood pressure
  - fasting glucose or HbA1c
  - fasting lipid panel
  - extrapyramidal symptoms using Abnormal Involuntary Movement Scale (AIMS)
- Has a documented plan for taper/discontinuation of the Antipsychotic drug
- Has a documented rationale for continued use of the Antipsychotic drug

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

**Prescriber Signature:**

**Date:**

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