ATYPICAL ANTIPSYCHOTICS (Second Generation) PRIOR AUTHORIZATION FORM

SD DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for an atypical antipsychotic (second generation) considered to be an alternate dosage form (e.g., rapid dissolve tablets, injectables) or an isomer/metabolite of a covered agent must first try and fail one of the agents listed below.

- Traditional antipsychotics (first generation) do not require a prior authorization.
- Abilify (aripiprazole), Zyprexa (olanzapine), Seroquel (quetiapine), Geodon (ziprasidone), clozapine, and risperidone do not require a prior authorization when written for their standard tablet/capsule dosage form.
- Patients currently stabilized on an atypical antipsychotic (second generation) will not be asked to change medication.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:		PHYSICIAN DEA NUMBER:
City:	PHONE: ( )	FAX: ( )

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed) **Diagnosis for this request:**	
Qualifications for coverage:	
☐ Unable to swallow the standard tablet/capsule dosage form	☐ Currently being discharged from an inpatient mental health facility
Adverse Reaction (attach FDA MedWatch form) or contraindication: (provide description below):	
Medical Justification for use of alternate dosage forms or isomers/metabolites of a covered agent without trial of a tier one agent:	
Physician Signature:	**Date:**

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ( ):	FAX:: ( )
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _________
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	