

Health Plan Select
Step Therapy
Atypical Antipsychotics
(Geodon, Seroquel, and Zyprexa)

If the following information is not complete, correct, or legible the PA process will be delayed.

Member Name: _____ Member ID: _____

Date of Birth: _____ Prescriber Name: _____

Prescriber Phone #: _____ Prescriber Fax #: _____

Medication requested: _____ Strength: _____

Clinical Criteria Documentation:

1. What is the diagnosis for this medication?

- Bipolar Disorder Schizophrenia/Schizoaffective Disorder Psychotic Disorder
- Psychotic depression Aggression/Impulse Control Disorder Agitation of Dementia
- Delusional Disorder Agitation/aggression in autism Severe refractory PTSD
- Severe refractory depression Severe Tic Disorder/Tourettes Severe refractory OCD
- Substance-induced psychotic disorder Agitation/aggression in mental retardation Syndrome
- Other _____

2. Has the patient had a failed trial or is intolerant to generic clozapine or risperidone? Yes NO

If yes, which medication? _____ Dose _____ Frequency _____

Duration _____ Reason for discontinuation _____

4. Does the patient have documented noncompliance to oral atypicals or non-responsive due to non-compliance?

- Yes NO

Prescriber Signature (required): _____ **Date:** _____

Fax completed form to (706) 549-8004

For questions related to this form please contact Member Services at (706) 549-0549, ext. 2 or 1-800-293-6260