

FLORIDA MEDICAID PRIOR AUTHORIZATION



ADULT ANTIPSYCHOTIC HIGH DOSE

Recipient's Medicaid ID # Date of Birth (MM/DD/YYYY)																		
			/		1													
Recipient's Full Name																		
Prescriber's Full Name																		
Prescriber's NPI			1		1	1	I						1	1	1		I	
Prescriber Phone Number Prescriber Fax Number																		
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Drug, Dose and Frequency: Diagnosis: Previous Antipsychotic Trials (include drug, maximum dose, duration, and trial dates): 1. 2. 3. Rationale for high dose antipsychotic (check all that apply): Failure to respond to clozapine During the switch of one antipsychotic to another Failure to respond to clozapine with augmentation																		
☐ Failure to tolerate clozapine					Other:													
Please provide the monitoring plan (including tapering schedule) in the space provided below.																		
Prescriber's Signature Date:																		

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Phone number for non-specialty Prior Authorization: 877-433-7643 Phone number for specialty Prior Authorization: 866-814-5506 Fax number for non-specialty Prior Authorization: 866-255-7569 Fax number for non-specialty Prior Authorization: 866-249-6155

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Call or Fax Information to: Florida Community Care Prior Authorization