Reset Form Print Form

FLORIDA COMMUNITY CARE

FLORIDA MEDICAID PRIOR AUTHORIZATION
ADULT ANTIPSYCHOTIC HIGH DOSE

CVS caremark

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

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
- ☐ Failure to respond to clozapine with augmentation
- ☐ Failure to tolerate clozapine
- ☐ During the switch of one antipsychotic to another
- ☐ As a temporary measure during an acute episode
- ☐ 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.**

Call or Fax Information to: Florida Community Care Prior Authorization
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