Reset Form Print Form

United Healthcare Community Plan

FLORIDA MEDICAID PRIOR AUTHORIZATION

# ADULT ANTIPSYCHOTIC HIGH DOSE

**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's Phone Number** - -

**Prescriber's 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.**

Fax this form to 1-866-940-7328

Pharmacy PA Call Center:
1-800-310-6826

02.01.2025