



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 #

Grid for Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY)

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

Recipient's Full Name

Grid for Recipient's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber's Phone Number

Grid for Prescriber's Phone Number

Prescriber's Fax Number

Grid for 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.

Large empty box for monitoring plan

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

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