BlueChoice® HealthPlan of South Carolina

Medicaid

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Mental Health Drugs

Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION

Patient Name: ______________________________

Patient ID #: ______________________________

Patient DOB: ______________________________

Date of Rx: ______________________________

Patient Phone #: ______________________________

Patient Email Address: ______________________________

2. PHYSICIAN INFORMATION

Prescribing Physician: ______________________________

Physician Address: ______________________________

Physician Phone #: ______________________________

Physician Fax #: ______________________________

Physician Specialty: ______________________________

Physician DEA: ______________________________

Physician NPI #: ______________________________

Physician Email Address: ______________________________

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
____________________	____________________	____________________	Specify: ______________

7. DIAGNOSIS: ____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

□ Yes □ No Patient is receiving **two** (2) or more tricyclic antidepressant medications

□ Yes □ No Patient is receiving **two** (2) or more typical antipsychotic medications

□ Yes □ No Patient is receiving **two** (2) or more atypical antipsychotic medications

□ Yes □ No Patient is receiving **three** (3) or more antipsychotic medications (total typical plus atypical)

□ Yes □ No Patient is receiving **three** (3) or more benzodiazepine medications

□ Yes □ No Patient is receiving **three** (3) or more antidepressant medications (excluding trazodone)

□ Yes □ No Patient is receiving **two** (2) or more sedatives/hypnotics, including trazodone

□ Yes □ No Patient is receiving **two** (2) or more SSRI/SNRI, excluding bupropion and mirtazapine

□ Yes □ No Patient is receiving **two** (2) or more stimulants having different core ingredients, excluding atomexetine

□ Yes □ No Patient is receiving **three** (3) or more anticonvulsants or mood stabilizers

□ Yes □ No Patient is between the ages of 18 and 64 AND receiving low dose atypicals defined as:

□ Aripiprazole < 10mg/day □ Olanzapine < 5mg/day □ Risperidone < 1mg/day

□ Ziprasidone < 40mg/day □ Quetiapine < 200mg/day

□ Yes □ No Patient has used the atypical antipsychotic prescription/s in the last six (6) months

□ Yes □ No Patient’s prescriptions are for the use of treating epilepsy or a seizure disorder

□ Yes □ No Patient’s prescriptions are written by, or in consultation with, a psychiatrist

□ Yes □ No Patient’s prescriptions are for DSM IV diagnosis

□ Yes □ No Patient’s prescriptions are for the purpose of tapering or cross tapering

9. PHYSICIAN SIGNATURE

____ ______________________________

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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