Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

ASAP: Antipsychotics for Members 18 Years of Age and Older

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
5. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity per 30 Days: _____
4. Length of Therapy (in days): ☒ 365 Days

Clinical Information

For Non-Preferred Medications:

1. ☐ Failed 1 preferred drug? ☐ **Yes** ☐ **No**
   List preferred drugs failed:_____
   a. Was the failure due to an allergic reaction? ☐ **Yes** ☐ **No**
   b. Was the failure due to a drug-to-drug interaction? ☐ **Yes** ☐ **No**
   Please describe reaction: _____
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure.
   Please provide clinical information: _____
   _____
3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
   Please provide clinical information: _____
4. ☐ Age specific indications. Please give patient age and explain: _____
5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference: _____
6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____
   _____

Criteria for All medications:

7. What is the beneficiary's Primary Psychiatric diagnosis? ☐ Attention Deficit-Hyperactivity Disorder
   ☐ Bipolar Disorder ☐ Disruptive Behavior Disorder ☐ Mood Disorder-NOS ☐ Any Pervasive Development Disorder
   ☐ PTSD ☐ Schizophrenia ☐ Schizoaffective Disorder ☐ Tourette's Syndrome ☐ Other: _____
8. What is the beneficiary's target symptom? ☐ Aggression ☐ Impulsivity ☐ Inattentiveness ☐ Irritability ☐ Mania
   ☐ Oppositional ☐ Psychosis ☐ Other: _____
9. Has the patient and/or guardian been informed of the potential metabolic adverse effects with this medication and wishes to continue to receive this therapy? ☐ **Yes** ☐ **No**
10. Has the patient and/or guardian been informed of the potential neurologic adverse effects with this medication and wishes to continue to receive this therapy? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

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Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277