BlueCross BlueShield of North Carolina | HealthyBlue

ASAP: Adult Safety with Antipsychotic Prescribing Prior Authorization Form Members 18 Years of Age and Older

Member Information		
1. Member last name:		2. Member first name:
3. Member ID #:	4. Member date of birth:	5. Member gender:
Prescriber Information		
6. Prescribing provider NPI#:		
7. Requester contact information		
Name:		
Phone:		Ext:
Drug Information		
8. Drug name:		9. Strength:
10. Quantity per 30 days:		
11. Length of therapy (in days): ☐ 365 days		
Clinical Information		
For Nonpreferred Medications		
1. Failed 1 preferred drug? ☐ Yes ☐ No List preferred drugs failed: _____ 1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____		
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:_____ ____		
3. ☐ Clinical contraindication, comorbidity, or unique member circumstance as a contraindication to preferred drug(s). Please provide clinical information: _____ _		
4. ☐ Age specific indications. Please give member 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 member'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 member's target symptom? ☐ Aggression ☐ Impulsivity ☐ Inattentiveness ☐ Irritability ☐ Mania ☐ Oppositional ☐ Psychosis ☐ Other:_____ 9. Has the member 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 member and/or guardian been informed of the potential neurologic adverse effects with this medication and wishes to continue to receive this therapy? ☐ Yes ☐ No		

https://provider.healthybluenc.com

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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.	

Fax this form to **844-376-2318**
Healthy Blue Pharmacy PA Call Center: **844-594-5072**