38826

NORTH CAROLINA MEDICAID
Adult Safety with Antipsychotic Prescribing

Request Date ___ / ___ / ____

RECIPIENT INFORMATION

Recipient's Medicaid ID Number

Recipient's Date of Birth ___ / ___ / ____

Recipient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Phone: ___ - ___ - ____

Prescriber Fax: ___ - ___ - ____

Prescriber NPI #

Prescriber DEA # ___ - _____

Drug Requested:

Strength _____ Quantity _____ Length of Therapy on Prescription _____ Dosing Instructions _____

a) Primary psychiatric diagnosis:_____

b) Primary target symptom for use of the antipsychotic medication ( ) psychosis, ( ) mania, ( ) irritability, ( ) aggression, ( ) impulsivity, ( ) inattentiveness, ( ) other:_____)

c) Has the patient and/or guardian been informed of the potential for metabolic adverse effects with this medication and wishes to continue to receive this therapy ( ) yes ( ) no ( ) na

d) Has the patient and/or guardian been informed of the potential for neurologic adverse effects with this medication and wishes to continue to receive this therapy ( ) yes ( ) no ( ) na

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 TO: **NORTH CAROLINA Medicaid Prior Authorizations**
Fax: (866)-246-8507
PA HELPDESK: (866) 246 - 8505

38826