State of Illinois
Department of Healthcare and Family Services

Date _____

Prior Authorization Request Form

Long Acting Injectable Atypical Antipsychotics

Fax completed form: 217-524-7264 Prior Authorization Hotline**:** 800-252-8942

Patient Information (required):

Name: _____

DOB: _____

Nine-Digit HFS ID Number: _____

Prescriber Information (required):

Name: _____

Phone: _____

Fax: _____

NPI #: _____

Pharmacy Information:

Pharmacy Name: _____

Phone: _____

Fax: _____

NPI #: _____

Contact person for this request (required):

Name: _____

Phone: _____ Ext.: _____

Fax: _____

Clinical Information

Requested Medication

Preferred	Non-Preferred
☐ Invega Sustenna	☐ Zyprexa Relprevv
☐ Invega Trinza	☐ Risperdal Consta
☐ Invega Hafyera	☐ Rykindo
☐ Aristada	☐ Perseris
☐ Aristada Initio	
☐ Abilify Maintena	
☐ Abilify Asimtufii	

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1. Medication: _____ Strength: _____ Dosage Form: _____

   NDC (if available): _____ Quantity: _____ Days Supply: _____ Refills: _____

   Start Date of this Request: _____ Dosing Frequency: _____ Duration of Therapy: _____

   ICD-10 Code / Diagnosis: _____

2. Is this a renewal request? ☐ Yes ☐ No

   ****If *initiating* Sustenna at a dose *other* than Sustenna 234mg or Maintena 400mg, please provide justification**:

   _____

3. Prescriber is a psychiatrist: ☐ Yes ☐ No

   If no, please indicate specialty: _____

4. Diagnosis is schizophrenia: ☐ Yes ☐ No

   If no, please specify: _____

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5. Reason for prescribing a long-acting injectable antipsychotic:
   - ☐ Nonadherence to oral antipsychotics
   - ☐ Other (please explain): _____

6. If patient is able to take other oral medication or is in a LTC facility, please explain why oral antipsychotics cannot be given:

_____

7. Patient has had previous exposure to which oral antipsychotics? List all:

_____

8. **Maintena**: Intention to discontinue oral antipsychotics after 14 days of Maintena therapy: ☐ Yes ☐ No

   Aristada: Intention to discontinue oral antipsychotics after 21 days of Aristada therapy: ☐ Yes ☐ No

   Current oral aripiprazole dose: _____

   Sustenna: Intention to discontinue oral antipsychotics before 1st Sustenna injection: ☐ Yes ☐ No

   Consta: Intention to discontinue oral antipsychotics after 21 days of Consta therapy: ☐ Yes ☐ No

   Relprevv: Intention to observe in registered facility with ER services for 3 hours after 1st Relprevv injection: ☐ Yes ☐ No

   Trinza: Initiated after stabilization of at least 4 months of Invega Sustenna treatment: ☐ Yes ☐ No

   Hafyera: Initiated after stabilization of at least 4 months of Invega Sustenna treatment or a full 3 month cycle of Invega Trinza: ☐ Yes ☐ No

   If no to any of the above, please explain:

9. Is patient being discharged from a hospital or institution on this medication? ☐ Yes , date of last dose: _____ ☐ No

   If answer is yes, who (provide NPI if able) if not this prescriber will follow up with the patient for future doses, and when?

Provider's Signature: _____ Date: _____

Name: _____ DOB: _____ RIN: _____