LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
hope. recovery. wellbeing.

Fax to Magellan Pharmacy Solutions: (800) 424-7385
Phone: (800) 424-6811

ORALLY DISINTEGRATING TABLET PRIOR AUTHORIZATION REQUEST FORM

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review (e.g. chart notes, medication history, lab results, etc.) to support the ODT prior authorization request.

Client Information: This must be filled out completely to ensure HIPAA compliance

First Name:	Last Name:	MI:	Date of Birth (MM/DD/YYYY):	Gender:

Client IS #:	Client Magellan #:

Prescriber/Furnisher Information

Please check one: ☐ Psychiatrist ☐ Physician Assistant ☐ Nurse Practitioner ☐ Clinical Pharmacist

First Name:	Last Name:	NPI Number (individual):	DEA Number (if required):

DMH Site/Clinic Name:	Phone Number:	Fax Number (in HIPAA compliant area):

Medication/Medical and Dispensing Information

Medication Name (select **ONE**):	Dose/Strength:	Frequency:	Length:
☐ Aripiprazole (Abilify) ODT ☐ Asenapine (Saphris) Sublingual ☐ Clozapine (Clozaril) ODT ☐ Mirtazapine (Remeron) SolTab ☐ Olanzapine (Zyprexa) ODT ☐ Risperidone (Risperdal) M-Tab ☐ Topiramate (Topamax) Sprinkle			

☐ New Therapy ☐ Renewal If Renewal, Date Therapy Initiated:	How did the patient receive the medication? ☐ Paid under insurance name: _____ ☐ LA County/Indigent ☐ Samples (*not an acceptable justification for continuation of therapy*)

Has the patient tried any other medications for this condition? ☐ **YES** (*if yes, complete below and provide documentation*) ☐ **NO**

Medication/Therapy (Specify Drug Name and Dosage)	**Duration of Therapy** (Specify Dates)	**Response/Reason for Failure/Allergy**

List Diagnoses	ICD-10

<u>REQUIRED CLINICAL INFORMATION</u>: Please provide all relevant clinical information (e.g. chart notes, medication history, lab results, etc.) to support the ODT prior authorization request.

Please attach documented symptoms, non-compliance issues and/or justification for initial or ongoing therapy or increased dose and if patient has any contraindications for the preferred drug. Please provide any additional clinical information or comments pertinent to this request for coverage or required under state and federal laws.

☐ Unable to swallow or absorb oral medications
☐ Poor adherence
☐ Other medical reason(s) for the ODT formulation: _____

☐ Attachments:
- ☐ Chart Notes (e.g. Avatar)
- ☐ Medication History (e.g. Order Connect)
- ☐ Other: _____

Attestation: I attest the information provided is true and accurate to the best of knowledge. I understand that the insurer or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber/Furnisher Signature: _____ Date: _____

Supervising Physician's Signature: _____ Date: _____
(Required only for Physician Assistants, Clinical Pharmacists, and Nurse Practitioners)
(Prior Authorizations received on Friday after 12 p.m. will be reviewed on the next business day)

LAC DMH Pharmacy Services Use Only
Date of Decision: _____
□ Approved
Length: _____
□ Denied
Comments/Information Requested: _____
□ Return Fax
Comments/Information Requested:_____