Aetna Better Health® of Florida (MEDICAID)

ADULT ANTIPSYCHOTIC HIGH DOSE

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID #

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber's Phone Number ___ - ___ - ____

Prescriber's Fax Number ___ - ___ - ____

Drug, Dose and Frequency: _____

Diagnosis: _____

Previous Antipsychotic Trials (include drug, maximum dose, duration, and trial dates):

1. _____ _____
2. _____ _____
3. _____ _____

Rationale for high dose antipsychotic (check all that apply):

- ☐ Failure to respond to clozapine
- ☐ Failure to respond to clozapine with augmentation
- ☐ Failure to tolerate clozapine
- ☐ During the switch of one antipsychotic to another
- ☐ As a temporary measure during an acute episode
- ☐ Other: _____

Please provide the monitoring plan (including tapering schedule) in the space provided below.

Prescriber's Signature: _____ **Date:** _____

REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.

Fax completed prior authorization request form to Aetna Better Health of Florida at 855-799-2554 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.