Reset Form Print Form

Lighthouse HEALTH PLAN

FLORIDA MEDICAID PRIOR AUTHORIZATION

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 Phone Number - -

Prescriber 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.**

Mail or Fax Information to:
Lighthouse Health Plan
P.O. Box 211156
Eagan, MN 55121
Phone: 844-716-5412
Fax: 866-265-5511

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