 

 **PHARMACY SERVICES**

**Behavioral Health – Injectable Drugs**

**Prior Authorization Form**

{Applicable for HPN/SHL Commercial/Medicaid Members only}

 **Member Name:** **Date of Request:**

**Primary Cardholder ID #:** **M / F DOB:**

**Physician Information - COMPLETE INFORMATION IS REQUIRED TO RECEIVE RESPONSE**

**Physician Name (please print clearly):**

**Phone:** **FAX:**

**Provider Group Name/Address:**

**Office Contact Person:**

***NOTICE: Prescriptions for haloperidol or fluphenazine do not require PA. Send directly to Genoa***

**REQUESTED MEDICATION:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| [ ]  **Abilify Maintena** | [ ]  **Aristada** | [ ]  **Invega Sustenna** | [ ]  **Invega Trinza** | [ ]  **Risperdal Consta** |
| [ ]  **Perseris**  | [ ]  **Zyprexa Relprev**  | [ ]  **Vivitrol** | [ ]  **Sublocade** | [ ]  **Other:** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Dose/Strength** | **Directions** | **Quantity** | **Refills** |
|  |  |  |  |
| **Diagnosis** |  |

**PROVIDER ATTESTS TO THE FOLLOWING:**

|  |  |  |
| --- | --- | --- |
| **Long-Acting Injectable Antipsych ONLY** | **Choose ONE** | [ ]  **A – Patient is non-adherent with oral atypical antipsychotic dosage forms** |
| [ ]  **B – Patient is unable to take oral solid alternatives** |
| **Check Box** | [ ]  **C – Patient has established tolerability with the corresponding oral formulation or previous use of the requested injectable** |

**OR**

|  |  |  |
| --- | --- | --- |
| **Sublocade ONLY** | **Check Both** | [ ]  **A – Patient is currently maintained on an 8mg to 24mg per day dose of oral, sublingual, or transmucosal buprenorphine product equivalent for at least 7 days prior to initiation of extended-release buprenorphine injection** |
| [ ]  **B – Patient has not, nor will receive supplemental, oral, sublingual, or transmucosal buprenorphine** |

**SEND PRESCRIPTION TO:**

|  |  |  |
| --- | --- | --- |
| **Genoa Healthcare Pharmacy*****Note: Flamingo location cannot fill Sublocade*** | **PHONE: (702) 410-8746 FAX: (702) 997-1767** | **2500 W. Washington Ave. Suite 103 Las Vegas, NV 89106** |
| **PHONE: (725) 228-4850 FAX: (702) 425-9962** | **3430 E. Flamingo Road, Suite 103****Las Vegas, NV 89121** |

 **SEND FORM TO:**

|  |  |  |
| --- | --- | --- |
| **HPN/SHL - PHARMACY SERVICES** | **PHONE: (702) 242-7050, #6FAX : (702) 242-6751** | **P.O. Box 15645  Las Vegas, NV 89114-5645** |