UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Nuplazid (pimavanserin)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(all must be met)*

- ❑ Diagnosed with hallucinations and delusions associated with Parkinson's disease psychosis.
- ❑ The provider attests that the intended use is not for the treatment of dementia-related psychosis **unrelated** to the hallucinations and delusions associated with Parkinson's disease psychosis.

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response.

Initial Authorization: Up to six (6) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date