CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Saphris / Latuda**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Incomplete responses may delay this request.			
Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone #:		Provider Fax #:	Provider NPI #:
Patient Name:	CCHP Member ID #:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Quantity Dispensed (including units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	**Yes** ☐ **No** ☐
Diagnosis:		**Date of diagnosis:**	

Please indicate place of administration:
Physician's Office ☐ **Hospital/Facility** ☐ **Patient Home** ☐ **Other** ☐

Please provide hospital/facility information: Name: _____ Phone #: _____ Address: _____ _____	Will the drug be: (select one) **Billed medically using a JCODE** **JCODE:** _____ **Billed at a pharmacy** ☐

Medical History

Has the member tried and failed atypical antipsychotic medications? **Yes** ☐ **No** ☐

Please list antipsychotic medications:	Dates of therapy:	Reasons for discontinuation:

History of previous medications used to treat the above condition

Medication Name	Date of Therapy		Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing
	Start Date	End Date			

Please provide any additional clinical information which should be considered in the space below: