Prior Authorization Request Form for
Pimavanserin (Nuplazid)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question 2	☐ No Stop Coverage not approved
2. Does the patient have a diagnosis of hallucinations and/or delusions associated with Parkinson's disease psychosis?	☐ Yes Proceed to question 3	☐ No Stop Coverage not approved
3. Is the requested medication being prescribed by or in consultation with a neurologist, psychiatrist, or gerontologist (geriatric medicine specialist)?	☐ Yes Proceed to question 4	☐ No Stop Coverage not approved
4. Has the prescribing physician attempted to adjust the Parkinson's disease medications in order to reduce psychosis without worsening motor symptoms before requiring Nuplazid (pimavanserin)?	☐ Yes Proceed to question 5	☐ No Stop Coverage not approved
5. Does the patient have a Mini-Mental State Examination (MMSE) score of greater than or equal to 21?	☐ Yes Proceed to question 6	☐ No Stop Coverage not approved
6. Does the patient have a history of known QT prolongation, cardiac arrhythmias, or other circumstances that would increase the risk of Torsades de Pointes and/or sudden death?	☐ Yes Stop Coverage not approved	☐ No Proceed to question 7
7. Is the patient taking additional antipsychotics?	☐ Yes Stop Coverage not approved	☐ No Sign and date below

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[6 March 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered:

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	Name:
Date Faxed to MD:	Date Decision Rendered: