US Family Health Plan
Prior Authorization Request Form for
Pimavanserin (**Nuplazid**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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

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

Prescriber Signature _____ Date _____

[6 March 2019]