46199

Maryland Pharmacy Program
Atypical Antipsychotic
Quantity Limit Override Request Form

Request Date ☐☐ / ☐☐ / ☐☐☐☐

PATIENT INFORMATION

Patient's Medicaid ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Patient's Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City **State** **Zip Code** - ☐☐☐☐

Prescriber Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Prescriber Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Is prescriber a Psychiatrist? ○ Yes ○ No

If no, indicate area of practice (such as Internal Medicine, Family Practice). _____

DEA# ☐☐ - ☐☐☐☐☐☐☐

Maximum Quantity Override Request for Drug:

Strength _____ **Quantity Per Month** _____

Table of Dosage Optimization Limits for Atypical Antipsychotic Drugs published on website: http://www.dhmh.state.md.us/mma/mpap/forms.htm

Justification for use of quantities greater than published:

Diagnosis (Do not use ICD-9 codes) _____

Please check all that apply:

○ Yes ○ No **1. Patient cannot tolerate recommended dose due to adverse effect of** _____

○ Yes ○ No **2. Patient's dose is being titrated and will change within a few weeks. (PA only valid one time up to 34 days)**

○ Yes ○ No **3. Patient has failed recommended regimen and requires more frequent dosing to receive clinical benefits of drug**

○ Yes ○ No **4. Other reason, please specify** _____

I certify that use of high quantities of atypical antipsychotic for this patient is justified and medically necessary.

Signature of Prescriber_____ **Date** ☐☐ / ☐☐ / ☐☐☐☐

FAX TO: Maryland Pharmacy Program

Fax: (866) 440 - 9345

PA HELPDESK: (800)932-3918

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Revised - April 2009