Superior HealthPlan Prior Authorization Form
Saphris® (asenapine)

1. Patient Information

First Name:	Last Name:	Middle Initial:

Medicaid ID Number:	Date of Birth:	Diagnosis:

2. Current Antipsychotic Therapy

Drug Name and Strength	Quantity	Last Fill Date	Prescriber Name

3. Drug Therapy Resolution (Check appropriate box)

☐ **1 . I have not prescribed Saphris® to any Superior HealthPlan member since August 1, 2014.**

☐ **2 . I no longer see this patient. Please indicate last patient visit date: ____________________**

☐ **3 . I will change this medication to a preferred product** (Please send pharmacy the new prescription).

☐ **4 . There is no acceptable alternative pharmaceutical agent on the Preferred Drug List (PDL).**

☐ **5 . Therapeutic failure of alternative PDL products** (Please list previous trials in the space below).

☐ **6 . Contraindication or adverse reaction to preferred agent(s)** (Please describe in the space below).

☐ **7. Changing to a preferred product would incur unacceptable therapeutic risk.**

4. Recent Labs

Date of Triglycerides:	Date of LDL:	Date of HbA1C:	Date of Blood Glucose:

5. Prescriber Information

Prescriber Name (Print):	NPI:	TX License:

If applicable, name of designee completing form (Print):

Prescriber Signature:	Date:

Telephone Number:	Fax Number:

Please Note: Incomplete forms may cause unnecessary delays in the approval process.

Please fax completed form to: US Script at 1-866-399-0929 prior to 4/14/2015.

Rev. 01/2015
SHP_2015892A