02/18/2015

Fallon Community Health Plan

FCHP - FALLON COMMUNITY HEALTH PLAN

Saphris (FCHP)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Fallon Community Health Plan at 1-888-836-0730.
Please contact Fallon Community Health Plan at 1-866-772-9538 with questions regarding the Fallon Community Health Plan process.
When conditions are met, we will authorize the coverage of Saphris (FCHP) .

Drug Name (select from list of drugs shown)

Saphris (asenapine sublingual tablets)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N
   [If no, then skip to question 3.]
2. Is the patient tolerating and responding to medication and there continues to be a medical need for the medication? Y N
   [No further questions required]
3. Does the patient have dementia-related psychosis? Y N
4. Does the patient have a clinical diagnosis of Schizophrenia or Bipolar Disorder (including manic and mixed episodes associated with bipolar disorder)? Y N
5. Is the patient 18 years of age or older? Y N
6. Has the patient had a trial and failure of or intolerance to at least TWO formulary atypical antipsychotics such as Zyprexa (olanzapine), Seroquel (quetiapine), Risperdal (risperidone), Y N

Clozaril (clozapine) or Geodon (ziprasidone)?

[If the answer to this question is yes, then no further questions required.]

7. Does the patient have an inability to swallow pills? Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date