

**USE OF CLOZAPINE, OLANZAPINE, RISPERIDONE, QUETIAPINE AND ZIPRASIDONE  
(Circle One)**

**I. CRITERIA**

- A. For Olanzapine, Risperidone, Quetiapine and Ziprasidone
  1. The patient is actively symptomatic with positive and/or negative schizophrenic symptoms.
  2. The patient is functionally disabled.
  3. The patient is participating in appropriate concomitant treatment and rehabilitation.
  4. The patient has been treated for a reasonable period of time with at least two different classes of neuroleptics without satisfactory results, or is unable to be treated with neuroleptic medications due to severe adverse effects.
- B. For Clozapine (for Schizophrenia)
  1. The patient has been treated with Olanzapine, Risperidone or Quetiapine for a reasonable period of time without satisfactory results or has severe adverse effects from them.
- C. For Clozapine (for movement disorders)
  1. The patient is actively symptomatic with dyskinesia(s).
  2. The patient has been treated for a reasonable period of time with two different antitremor medications without satisfactory results, or is unable to be treated with antitremor medications due to severe adverse effects.

**II. PATIENT DATA (Every item must be completed, use 'None' or 'N/A' if not applicable)**

\_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex \_\_\_\_ M \_\_\_\_ F  
 (Last Name, First Name)

\_\_\_\_\_ Diagnosis : \_\_\_\_\_ DSM-IV Code: \_\_\_\_ . \_\_\_\_  
 (Medical ID #)

How long have you treated this patient? \_\_\_\_\_

Name(s) of previous psychiatrist(s)/neurologist(s) \_\_\_\_\_

Describe patient's positive schizophrenic or movement disorder symptoms: \_\_\_\_\_

Describe patient's negative schizophrenic symptoms: \_\_\_\_\_

List patient's previous antipsychotic or antitremor medication(s):

| <u>NAME OF MEDICATION</u> | <u>DOSAGE/FREQUENCY</u> | <u>DATE USED:</u> |
|---------------------------|-------------------------|-------------------|
| _____                     | _____                   | _____ to _____    |
| _____                     | _____                   | _____ to _____    |
| _____                     | _____                   | _____ to _____    |
| _____                     | _____                   | _____ to _____    |

Have symptoms of Tardive Dyskinesia ever been present? \_\_\_\_ Yes \_\_\_\_ No

Psychiatric hospitalizations within the past five years:

| <u>HOSPITAL</u> | <u>LOCATION</u> | <u>DATE</u> |          |
|-----------------|-----------------|-------------|----------|
| _____           | _____           | _____       | to _____ |
| _____           | _____           | _____       | to _____ |
| _____           | _____           | _____       | to _____ |
| _____           | _____           | _____       | to _____ |

III. PROCEDURES:

A. The following forms and information shall be submitted:

1. DHS 1144 Request For Prior Medical Authorization
2. DHS 1162 Revised 03/01
3. Brief Psychiatric Rating Scale (BPRS) report (Not required for movement disorders)

FAX all completed forms to:

ACS  
PA Desk  
Fax number: 1-888-335-8474

B. Brief Psychiatric Rating Scale (BPRS) reports are required with every DHS 1162 that is submitted (Not required for movement disorders). When the BPRS is stable (little or no change from last report), a narrative report (indicating that the patient is stabilized and reason(s) for continuing the medication) must be submitted in lieu of the BPRS.

C. The use of Clozapine, Olanzapine, Risperidone, Quetiapine or Ziprasidone may be suspended if the patient has not improved or for other good reason(s).

I certify that the above information is true and will carefully monitor the patient's condition.

\_\_\_\_\_  
(Physician's Signature) (Type or print Physician's Name) Date

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*(For Consultant's Use Only)*

Approved \_\_\_\_\_ Denied \_\_\_\_\_

\_\_\_\_\_  
Consultant's Signature Date