



Utilization Management Form

Please Fax to: (866) 855-2676

Date of Request: _____

Physician's Name: _____

Physician's DEA#: _____ Specialty: _____

Phone #: (____) _____ Fax #: (____) _____

Patients Name: _____ DOB: _____ Gender: _____

ID#: _____ Patient's Diagnosis: _____

Medication Needed: _____ Strength: _____

Quantity: _____ Directions: _____ Duration: _____

Has this patient tried other medications for this condition? (List drug, duration, results)

Clinical justification for combination atypical antipsychotic therapy:

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