Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049

Important Information About Prescription Drug Coverage

To: From:

Fax: Pages:

Re: Geodon® (ziprasidone): Quantity Limit Exception Form: Please respond.

- Please complete the attached Geodon® (ziprasidone) Quantity Limit Exception Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Geodon® (ziprasidone)
Expert consensus statements from the J Clin Psychiatry recommends the target dose in treatment resistant patients should not exceed 220 mg/day. Expert consensus recommends maximum dose in patients > or =65 years of age be limited to 140 mg/day. Higher doses may increase risk of QT prolongation. The maximum oral daily dose under our quantity limit program is 240 mg/day; higher doses are not supported by the literature or experts within the field of psychiatry.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

Quantity Limit Exception Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name ______________________

Member ID ______________________

Medicare ID ______________________

Date of birth ______________ Sex: M / F

Address ______________________

City ______________________

State __________ ZIP __________

Phone ______________________

Nursing home resident? YES / NO

Home care patient? YES / NO

Prescriber and Pharmacy Information

Name ______________________

Specialty ______________________

DEA ______________________

NPI ______________________

Address ______________________

City ______________________

State __________ ZIP __________

Phone __________ Fax __________

Pharmacy name ______________________

NCPDP ______________________

NPI ______________________

Phone __________ Fax __________

All items below this line are for Physician Use Only

Information for Requested Drug

Strength:________ Dosage form:__________ Qty per 30 days:________ Drug is (circle one): Newly prescribed/Refill

Directions:____________________ Diagnosis:______________ ICD-9 Code:__________

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Geodon® (ziprasidone) Criteria

1 Please indicate product requested:
☐ Geodon® caps ☐ Geodon® injection

2 Please specify indication for Geodon® use:
☐ Schizophrenia or other chronic psychotic disorders
☐ Bipolar Disorder
☐ Behavioral disturbances in the elderly that impair functional ability
☐ Other ....

3 Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.
☐ ICD-9: ....

4 If Geodon® injection is requested, please indicate dispensing location:
☐ the pharmacy
☐ the physician's supply, incident to a physician's service
☐ other: ....

5 Is the patient greater than or equal to 65 years old?
☐ Yes ☐ No

6 Is the patient currently taking Geodon®?
☐ Yes ☐ No

7 Is the patient taking Geodon® with food?
☐ Yes ☐ No ☐ Not applicable

▫ If the answer to question #6 was yes, then answer the following:

8 Is the patient compliant to the medication regimen (taken 95% of doses in last 30 days)?
☐ Yes ☐ No

9 How long has the current dose been used?
☐ < 1 month ☐ > 1 month

10 Please indicate which of the following best describes your patient's antipsychotic regimen:
☐ The patient receiving an enzyme inducer (e.g., carbamazepine).
☐ The patient received a partial response and is tolerating the current dose.
☐ The patient receiving more than one atypical antipsychotic agent and is not in the process of dosage cross titration.

▫ Geodon® absorption is increased up to two-fold when administered with food. A lipid panel, fasting glucose, weight, BMI, and BP should be evaluated prior to initiation & periodically thereafter

Medical Justification: (Attach additional page if necessary): ______________________

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Prescriber's signature:______________________ Date:______________