



thioridazine
(Mellaril)

Express Scripts
Prior Authorization
Phone (800) 417-8164
Fax 877-837-5922

Please have the information below ready when calling in the authorization.

Member's Last Name	Member's First Name
VH ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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1. Is the patient stabilized on the medication and new to SCAN Health Plan?
2. Is the diagnosis or indication for schizophrenia or psychosis?
3. Was the prescription initiated or written by a Psychiatrist?
4. Has the patient tried and failed at least 4 different anti-psychotics? Please specify the drugs tried and the dates.
5. Does the patient have a history of any heart arrhythmias, ischemic heart disease or stroke?
6. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.