Prior Authorization Form

CAREFIRST - DC EXCHANGE 5T

Atypical Antipsychotics Step Therapy (HMF)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-855-582-2022** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Atypical Antipsychotics Step Therapy (HMF).

Drug Name (select from list of drugs shown)

Latuda (lurasidone) Rexulti (brexpiprazole) Saphris (asenapine)

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 the patient currently taking the requested drug with evidence of improvement? | Y N |
| [If yes, then no further questions.] | |
| 2. Has the patient experienced an inadequate treatment response after a trial of at least 30 days to one of the following generic products: A) aripiprazole, B) olanzapine, C) paliperidone, D) quetiapine, E) quetiapine extended release, F) risperidone, G) ziprasidone? | Y N |
| [If yes, then no further questions.] | |

| | | |
|---|---|---|
| 3. | Does the patient have an intolerance or contraindication that would prohibit a 30 day trial to one of the following generic products: A) aripiprazole, B) olanzapine, C) paliperidone, D) quetiapine, E) quetiapine extended release, F) risperidone, G) ziprasidone? | Y N |
| | [If yes, then no further questions.] | |
| 4. | Does the patient have a clinical condition for which there is no generic alternative or the generic alternatives are not recommended based on published guidelines or clinical literature? | Y N |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

| |
|---|
| **Prescriber (Or Authorized) Signature and Date** |