



Prior Authorization Form

Invega®/Seroquel XR®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [] Invega® [] Seroquel XR®

Date: _____ Patient ID#: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

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MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE

1. DIAGNOSIS FOR DRUG REQUESTED:

- [] Schizophrenia
[] Bipolar disorder
[] Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes blank rows for entry.

3. PATIENT HISTORY

a. Has the patient tried and failed or has a contraindication to any of the following?

- Arapiprazole (Abilify®) [] Yes [] No
• Risperidone (Risperdal®) [] Yes [] No
• Quetiapine fumarate immediate release (Seroquel®) [] Yes [] No
• Olanzapine containing product [] Yes [] No

b. Has the patient been stabilized in an institutional setting? [] Yes [] No

c. Is the patient currently stabilized? [] Yes [] No

Please add any other supporting medical information that may be useful in the decision-making process:

Blank lines for providing additional medical information.

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

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