AmeriHealth

Prior Authorization Form

Fanapt®/Invega®/Saphris®/Seroquel XR®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: ☐ **Invega®** ☐ **Seroquel XR®** ☐ **Fanapt®** ☐ **Saphris®**

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
☐ Schizoaffective 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."

Drug Name	Date	Duration

3. PATIENT HISTORY

a. Has the patient tried and failed 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

d. Is this a request for continuous therapy? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

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