

## PRIOR AUTHORIZATION REQUEST FORM

### BRANDED ORAL ANTIPSYCHOTICS

Caplyta®, Fanapt®, Rexulti®, Vraylar®

**For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.**

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

**Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.**

**Product being requested:**  Caplyta® (lumateperone),  Fanapt® (Iloperidone),  Rexulti® (brexpuprazole),  
 Vraylar® (cariprazine)

Dosing/Frequency: \_\_\_\_\_

#### If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is this request for an expedited review? By checking the "Yes" box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	<input type="checkbox"/>	<input type="checkbox"/>	

#### FOR BIPOLAR DISORDER

1. Does clinical documentation show a diagnosis of bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show an adequate trial and failure of at least two preferred generic antipsychotic medications (e.g. aripiprazole, lurasidone, olanzapine, quetiapine, risperidone)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show an adequate trial and failure of a preferred generic mood stabilizer (e.g., valproate, lithium, lamotrigine)?			<b>Please provide documentation</b>

#### FOR MAJOR DEPRESSIVE DISORDER

1. Does clinical documentation show a diagnosis of major depressive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
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2. Does documentation show an adequate trial and failure of at least three different classes of antidepressant medications [e.g., a selective serotonin reuptake inhibitor (SSRI), a selective serotonin/norepinephrine reuptake inhibitor (SNRI), and a dopamine/norepinephrine reuptake inhibitor (DNRI)]?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
3. Does documentation show an adequate trial and failure of at least four generic antipsychotic medications (e.g. aripiprazole, lurasidone, olanzapine, quetiapine, risperidone) used in combination with an antidepressant?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
4. Does documentation show that requested therapy will be used as an adjunct to current antidepressant therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>FOR SCHIZOPHRENIA</b>			
1. Does clinical documentation show a diagnosis of schizophrenia?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. Does documentation show an adequate trial and failure to clozapine AND at least two preferred generic antipsychotic medications (e.g. aripiprazole, lurasidone, olanzapine, quetiapine, risperidone)?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>REAUTHORIZATION</b>			
1. Does clinical documentation show improvement or stabilization of the condition treated?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
2. For treatment of depression, is the member compliant with baseline antidepressant therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<b>Please provide documentation</b>
<b>What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.</b>			
Additional information:			
<b>PRESCRIBER CERTIFICATION</b>			
<b>I hereby certify this treatment is indicated, necessary and meets the guidelines for use.</b>			
<b>Physician's Signature:</b>			<b>Date:</b>

**\*\* Failure to submit clinical documentation to support this request will result in a dismissal of the request.\*\***

Policy: PHARM-168  
 Origination Date: 09/04/2025  
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