



Prior Authorization Form

Fanapt®/Invega®/Latuda®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [] Invega® [] Fanapt® [] Latuda®
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."

Table with 3 columns: Drug Name, Date, Duration. Includes horizontal lines for data entry.

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:

Horizontal lines for providing additional medical information.

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