



Prior Authorization Form

Invenga®/Seroquel XR®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: [ ] Invenga® [ ] Seroquel XR®
Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_
Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_
Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_
Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

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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 horizontal lines for data 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:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

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

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M F Rx coverage Y N STANDARD - SELECT LOB \_\_\_\_\_
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