



Please complete ALL information below and fax your request to 1-888-671-5285

### Rexulti® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information (required) |        |      | Provider Information (required) |                 |      |
|-------------------------------|--------|------|---------------------------------|-----------------|------|
| Member Name:                  |        |      | Provider Name:                  |                 |      |
| Insurance ID#:                |        |      | NPI#:                           | Specialty:      |      |
| Date of Birth:                |        |      | Office Phone:                   |                 |      |
| Street Address:               |        |      | Office Fax:                     | Office Contact: |      |
| City:                         | State: | Zip: | Office Street Address:          |                 |      |
| Phone:                        |        |      | City:                           | State:          | Zip: |

| Medication Information (required)  |           |              |
|--|-----------|--------------|
| Medication Name:<br>Select one of the following:<br><input type="checkbox"/> Request is for <b>GENERIC</b><br><input type="checkbox"/> Request is for <b>BRAND</b> (unable to take the generic)<br><input type="checkbox"/> Check if request is for <b>continuation of therapy</b> | Strength: | Dosage Form: |
| Directions for Use:  |           |              |

| Clinical Information (required)   |
|---|
| <b>Select the Type(s) of Coverage Determination Requested:</b><br><input type="checkbox"/> <b>Step Therapy</b> - Request is for an exception to try another drug before the requested drug being prescribed.  |
| <b>Select the diagnosis below:</b><br><input type="checkbox"/> Major depressive disorder (MDD)- adjunctive treatment<br><input type="checkbox"/> Schizophrenia<br><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____   |
| <b>Select the medication(s) the patient has a history of trial and failure, or intolerance to:</b><br><input type="checkbox"/> Aripiprazole<br><input type="checkbox"/> Olanzapine<br><input type="checkbox"/> Paliperidone<br><input type="checkbox"/> Quetiapine<br><input type="checkbox"/> Quetiapine extended-release (ER)<br><input type="checkbox"/> Risperidone<br><input type="checkbox"/> Ziprasidone |

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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