



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

Vraylar® Prior Authorization Request Form

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

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Depressive episodes associated with bipolar I disorder (bipolar depression)</p> <p><input type="checkbox"/> Manic or mixed episodes associated with bipolar I disorder</p> <p><input type="checkbox"/> Schizophrenia</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>Continuation of therapy:</p> <p>Has the patient been on continuous therapy with the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Select the medications the patient had an inadequate response to or inability to tolerate:</p> <p><input type="checkbox"/> Aripiprazole</p> <p><input type="checkbox"/> Clozapine</p> <p><input type="checkbox"/> Olanzapine</p> <p><input type="checkbox"/> Paliperidone</p> <p><input type="checkbox"/> Quetiapine</p> <p><input type="checkbox"/> Risperidone</p> <p><input type="checkbox"/> Ziprasidone</p> <p><input type="checkbox"/> Other generic antipsychotic(s) not listed above. (Please specify all agents): _____</p>

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

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

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