CAREFIRST - DC EXCHANGE 5T
Atypical Antipsychotics Step Therapy (HMF)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Atypical Antipsychotics Step Therapy (HMF).

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Vraylar (cariprazine)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Is the patient currently taking the requested drug with evidence of improvement?	**Y** ☐	**N** ☐
2.	Has the patient experienced an inadequate treatment response, after a trial of at least 30 days, to ONE of the following generic products: A) aripiprazole, B) asenapine, C) lurasidone, D) olanzapine, E) paliperidone, F) quetiapine, G) quetiapine extended-release, H) risperidone, I) ziprasidone?	**Y** ☐	**N** ☐
3.	Does the patient have an intolerance or a contraindication that would prohibit a 30-day trial of ONE of the following generic products: A) aripiprazole, B) asenapine, C) lurasidone, D) olanzapine, E) paliperidone, F) quetiapine, G) quetiapine extended-release, H) risperidone, I) ziprasidone?	**Y** ☐	**N** ☐
4.	Does the patient have a clinical condition for which there is no generic alternative, or the generic alternatives are not recommended based on published guidelines or clinical literature?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date