

SENTARA COMMUNITY PLAN (MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

Drug Requested: Vraylar® (cariprazine) for Major Depressive Disorder

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

- Vraylar is preferred and may be approved for members who are 18 years of age or older* and have one of the following FDA-approved diagnoses:
 - Schizophrenia in adults
 - Acute treatment of manic or mixed episodes associated with bipolar I disorder
 - Treatment of depressive episodes associated with bipolar I disorder (bipolar depression)
- The following clinical criteria only applies to the use of Vraylar for the treatment of Major Depressive Disorder (MDD).

*For pediatric patients (<18 years old) please refer to the Antipsychotics for Children prior authorization form

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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Initial Authorization: 12 months

- Member is 18 years of age or older
- Member has a diagnosis of Major Depressive Disorder
- Member must be adherent to complementary therapy with an antidepressant (e.g. selective serotonin reuptake inhibitor (SSRI) or serotonin/norepinephrine reuptake inhibitor (SNRI))
- Member has demonstrated adherence to complementary antidepressant therapy ($\geq 80\%$ of fills in the last 90 days) (**verified by pharmacy paid claims or must submit documentation**)

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member continues to meet **ALL** initial authorization criteria
- Member continues to remain adherent ($\geq 80\%$ of fills in the last 90 days) to a complementary antidepressant (e.g., SSRI or SNRI) (**verified by pharmacy paid claims or must submit documentation**)

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****