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.**

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).

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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.

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 (≥ 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 (≥ 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.****

***Approved by Pharmacy and Therapeutics Committee**:
REVISED/UPDATED/REFORMATTED: 6/20/2025