SENTARA HEALTH PLANS

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Atypical Antipsychotics

Drug Requested: (select one below)

❑ **asenapine** (generic Saphris®)	❑ **Caplyta®** (lumateperone)
❑ **Fanapt®** (iloperidone)	❑ **lurasidone** (Latuda®)
❑ **paliperidone** (generic Invega®)	❑ **Rexulti®** (brexpiprazole)
❑ **Vraylar®** (cariprazine)	

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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

❑ **If diagnosis is any type of depressive disorder, please list current antidepressant therapy:**

_____

_____

_____

_____

(Continued on next page)

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.

❑ **For all antipsychotics used for the treatment of bipolar disorder, major depressive disorder and/or Schizophrenia**

❑ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following:

❑ risperidone	❑ quetiapine/ER
❑ ziprasidone	❑ olanzapine
❑ aripiprazole	

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.

❑ **For Rexulti requests prescribed for Agitation Associated with Dementia due to Alzheimer's Disease**

Recommended Dosage: Initial: 0.5 mg once daily for 7 days, increase dose on days 8 to 14 to 1 mg once daily, then on day 15 to the target dose of 2 mg once daily. Based on response and tolerability, may increase dose after at least 14 days to the maximum dose of 3 mg once daily.

Quantity Limit: 1 tablet per day

❑ Prescribed by or in consultation with a neurologist or psychiatrist

❑ Member is 55 years of age or older

❑ Member has a confirmed diagnosis consistent with the findings of Alzheimer's disease with magnetic resonance imaging (MRI) or computed tomography of the brain **(must submit documentation)**

❑ Member has/is experiencing signs and symptoms of agitation characterized by increased, often undirected, motor activity, restlessness, aggressiveness, or emotional distress **(must submit chart note documentation)**

❑ Provider continues to monitor member for the occurrence of any medical or neurological conditions (other than Alzheimer's disease) that may be a contributing cause to the member's agitation

❑ Provider attests the risk-benefit has been discussed with patients, surrogate decision-makers, families, and or caregivers before starting treatment

❑ Member has documented use of non-pharmacological interventions (i.e., music therapy, re-direction of behaviors) prior to starting treatment **(must submit chart note documentation)**

(Continued on next page)

❑ Member has tried and failed **at least 30 days** of therapy with **two (2)** of the following:

❑ risperidone	❑ quetiapine/ER
❑ ziprasidone	❑ olanzapine
❑ aripiprazole	

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.*