Antipsychotics – 2nd Generation: cariprazine (Vraylar)

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for continuation of existing therapy? ☐ Yes ☐ No
   If yes, is patient is adherent and stabilized on the requested dose? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   - ☐ Bipolar I Disorder, acute mixed or manic episodes
   - ☐ Depressed bipolar I disorder
   - ☐ Schizophrenia
   - ☐ Other. Specify:

3. Does patient have a history of failure after 4 weeks, a contraindication, or intolerance to any of the following oral atypical antipsychotics? (check all that apply)

   - ☐ Aripiprazole
   - ☐ Asenapine
   - ☐ Clozapine
   - ☐ Fluoxetine
   - ☐ Iloperidone
   - ☐ Lurasidone
   - ☐ Olanzapine
   - ☐ Paliperidone
   - ☐ Quetiapine
   - ☐ Risperidone
   - ☐ Ziprasidone
   - ☐ Olanzepine + fluoxetine
   - ☐ Other. Specify:

4. Does patient have severe renal impairment (CrCl <30mL/min)? ☐ Yes ☐ No

5. Does patient have severe hepatic impairment (Child-Pugh ≥10)? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)