Catamaran Prior Authorization Department
Phone: 866-235-3062
Fax: 866-391-7222

Prescriber Information

Last Name:	**First Name**
DEA/NPI:	**Specialty:**
Phone	**Fax**

Member Information

Last Name:	**First Name**
Member ID Number	**DOB:**

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

Abilify
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Has the patient been established on therapy with the requested medication for greater than 60 days?	Y	N
2. Does the patient have a diagnosis of major depressive disorder?	Y	N
3. Did the patient have an inadequate treatment response to a trial of at least three different antidepressants? **Please Circle** • SSRIs: citalopram, escitalopram, sertraline, paroxetine, fluoxetine, fluvoxamine • SNRIs: venlafaxine, duloxetine • Serotonin modulators: trazodone, bupropion, mirtazapine • TCAs: amitriptyline, nortriptyline • Other: _____	Y	N
4. Did the patient have an adverse drug event or intolerance to 3 different antidepressants, as listed above?	Y	N
5. Does the patient have a diagnosis of schizophrenia?	Y	N
6. Does the patient have a diagnosis of bipolar disorder (manic or mixed type)?	Y	N
7. Does the patient have a diagnosis of irritability associated with autistic disorder?	Y	N

8. Has the patient had a trial and failure of 2 of the following atypical antipsychotics after at least 60 days of therapy? **Please Circle** • Olanzapine (generic form of Zyprexa) • Quetiapine IR (generic form of Seroquel) • Risperidone (generic form of Risperdal) • Ziprasidone (generic form of Geodon)	Y	N
9. Did the patient have an adverse drug event or intolerance to 2 of the generic atypical antipsychotics listed above?	Y	N

Abilify Discmelt
Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Has the patient been established on therapy with the requested medication for greater than 60 days?	Y	N
2. Is the patient unable to take tablets or capsules orally or at high risk for noncompliance?	Y	N
3. Is the patient taking other tablets or capsules indication that he or she can take non-dissolvable tablets?	Y	N
4. Does the patient have a diagnosis of major depressive disorder?	Y	N
5. Did the patient have an inadequate treatment response to a trial of at least three different antidepressants? **Please Circle** • SSRIs: citalopram, escitalopram, sertraline, paroxetine, fluoxetine, fluvoxamine • SNRIs: venlafaxine, duloxetine • Serotonin modulators: trazodone, bupropion, mirtazapine • TCAs: amitriptyline, nortriptyline • Other: _____	Y	N
6. Did the patient have an adverse drug event or intolerance to 3 different antidepressants, as listed above?	Y	N
7. Does the patient have a diagnosis of schizophrenia?	Y	N
8. Does the patient have a diagnosis of bipolar disorder (manic or mixed type)?	Y	N
9. Does the patient have a diagnosis of irritability associated with autistic disorder?	Y	N
10. Has the patient had a trial and failure of 2 of the following atypical antipsychotics after at least 60 days of therapy? **Please Circle** • Olanzapine (generic form of Zyprexa) • Quetiapine IR (generic form of Seroquel) • Risperidone (generic form of Risperdal) • Ziprasidone (generic form of Geodon)	Y	N
11. Did the patient have an adverse drug event or intolerance to 2 of the generic atypical antipsychotics listed above?	Y	N

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Fanapt, Invega, Saphris, Latuda, Seroquel XR, Fazaclo ODT and Versacloz Prior Authorization Criteria

You must answer ALL of the following questions that apply to patient		
1. Has the patient been established on therapy with the requested medication for greater than 60 days?	Y	N
2. Has the patient had a trial and failure of 2 of the following atypical antipsychotics after at least 60 days of therapy? **Please Circle** • Olanzapine (generic form of Zyprexa) • Quetiapine IR (generic form of Seroquel) • Risperidone (generic form of Risperdal) • Ziprasidone (generic form of Geodon)	Y	N
3. Did the patient have an adverse drug event or intolerance to 2 of the generic atypical antipsychotics listed above?	Y	N

Comments: _____

Information given on this form is accurate as of this date.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.

I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).