Prescriber Criteria Form

Fanapt 2025 PA Fax 4533-A v4 020125.docx
Fanapt (iloperidone)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Fanapt (iloperidone).

Drug Name:
Fanapt (iloperidone)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of schizophrenia? [If no, then skip to question 4.]	Yes ◯	No ◯
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) lurasidone, D) olanzapine, E) quetiapine, F) risperidone, G) ziprasidone? [If no, then no further questions.]	Yes ◯	No ◯
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following brand products: A) Caplyta, B) Lybalvi, C) Rexulti, D) Secuado, E) Vraylar? [No further questions.]	Yes ◯	No ◯
4	Is the requested drug being prescribed for the acute treatment of manic or mixed episodes associated with bipolar I disorder? [If no, then no further questions.]	Yes ◯	No ◯
5	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) olanzapine, D) quetiapine, E) risperidone, F) ziprasidone? [If no, then no further questions.]	Yes ◯	No ◯

6	Has the patient experienced an inadequate treatment response, intolerance, or has a contraindication to one of the following brand products: A) Lybalvi, B) Vraylar?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____