Prescriber Criteria Form Versacloz 2025 PA Fax 4553-A v2 020125.docx Versacloz (clozapine oral suspension) 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 Versacloz (clozapine oral suspension).

Drug Name: Versacloz (clozapine oral suspension)

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 to reduce the risk of recurrent suicidal behavior in a patient with schizophrenia or schizoaffective disorder? [If yes, then no further questions.]	Yes ◯	No ◯
2	Is the requested drug being prescribed for the treatment of a severely ill patient with schizophrenia who failed to respond adequately to standard antipsychotic treatment (i.e., treatment-resistant schizophrenia)? [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 generic products: A) aripiprazole, B) asenapine, C) lurasidone, D) olanzapine, E) quetiapine, F) risperidone, G) ziprasidone? [If no, then no further questions.]	Yes ◯	No ◯
4	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?	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:_____