Prescriber Criteria Form Seroquel XR 2026 PA Fax 2875-A v1 010126.docx Seroquel XR (quetiapine extended-release) 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 Seroquel XR (quetiapine extended-release).

Drug Name: Seroquel XR (quetiapine extended-release)

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 3.]	Yes	No
2	Has the patient had an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) lurasidone, D) olanzapine, E) quetiapine immediate-release, F) risperidone, G) ziprasidone? [If no, then no further questions.] [If yes, then skip to question 12.]	Yes	No
3	Is the requested drug being prescribed for any of the following: A) acute treatment of manic or mixed episodes associated with bipolar I disorder, B) maintenance treatment of bipolar I disorder? [If no, then skip to question 5.]	Yes	No
4	Has the patient had an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) olanzapine, D) quetiapine immediate-release, E) risperidone, F) ziprasidone? [If no, then no further questions.] [If yes, then skip to question 12.]	Yes	No
5	Is the requested drug being prescribed for acute treatment of depressive episodes associated with bipolar I disorder? [If no, then skip to question 7.]	Yes	No

6	Has the patient had an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) lurasidone, B) olanzapine, C) quetiapine immediate-release? [If no, then no further questions.] [If yes, then skip to question 12.]	Yes	No
7	Is the requested drug being prescribed for acute treatment of depressive episodes associated with bipolar II disorder? [If no, then skip to question 9.]	Yes	No
8	Has the patient had an inadequate treatment response or intolerance to generic quetiapine immediate-release? [If no, then no further questions.] [If yes, then skip to question 12.]	Yes	No
9	Is the requested drug being prescribed as adjunctive treatment of major depressive disorder (MDD)? [If no, then skip to question 11.]	Yes	No
10	Has the patient had an inadequate treatment response, intolerance, or contraindication to one of the following generic products: A) aripiprazole, B) olanzapine, C) quetiapine immediate-release? [If no, then no further questions.] [If yes, then skip to question 12.]	Yes	No
11	Is the requested drug being prescribed for monotherapy treatment of generalized anxiety disorder OR monotherapy treatment of major depressive disorder? [If no, then no further questions.]	Yes	No
12	Is the patient 65 years of age or older? [If no, then no further questions.]	Yes	No
13	Is the patient using two or more additional central nervous system (CNS) active medications (e.g., lorazepam, sertraline, clonazepam, escitalopram, alprazolam, zolpidem) with the requested drug? [If no, then no further questions.]	Yes	No
14	Has the prescriber determined that taking multiple central nervous system (CNS) active medications is medically necessary for the patient? [Note: Use of multiple central nervous system (CNS) active medications in older adults is associated with an increased risk of falls.]	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:_____