

Prescriber Criteria Form

Zyprexa Relprevv 2026 PA Fax 1483-A v1 010126.docx
Zyprexa Relprevv (olanzapine pamoate extended-release injectable 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 Zyprexa Relprevv (olanzapine pamoate extended-release injectable suspension).

Drug Name:
Zyprexa Relprevv (olanzapine pamoate extended-release injectable 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 for the treatment of schizophrenia? [If no, then no further questions.]	Yes	No
2	Has tolerability with oral olanzapine been established?	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:** _____