



## Antipsychotics – 2nd Generation: cariprazine (Vraylar)

Please provide the information below, please print your answers, attach supporting documentation, sign, date and return to our office as soon as possible to expedite this request.

**Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3.**

Date of Request			
Patient	Date of Birth	Molina ID	
Pharmacy Name	Pharmacy NPI	Telephone Number	Fax Number
Prescriber	Prescriber NPI	Telephone Number	Fax Number
Medication and Strength		Directions for Use	Qty/Days Supply
1. Is this request for continuation of existing therapy? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
If yes, is patient is adherent and stabilized on the requested dose? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
2. Indicate the patient's diagnosis:			
<input type="checkbox"/> Bipolar I Disorder, acute mixed or manic episodes <input type="checkbox"/> Depressed bipolar I disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other. Specify:			
3. Does patient have a history of failure after 4 weeks, a contraindication, or intolerance to any of the following oral atypical antipsychotics? (check all that apply)			
<input type="checkbox"/> Aripiprazole <input type="checkbox"/> Asenapine <input type="checkbox"/> Clozapine <input type="checkbox"/> Fluoxetine <input type="checkbox"/> Iloperidone <input type="checkbox"/> Lurasidone <input type="checkbox"/> Olanzapine <input type="checkbox"/> Paliperidone <input type="checkbox"/> Quetiapine <input type="checkbox"/> Risperidone <input type="checkbox"/> Ziprasidone <input type="checkbox"/> Olanzapine + fluoxetine <input type="checkbox"/> Other. Specify:			
4. Does patient have severe renal impairment (CrCl <30mL/min)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
5. Does patient have severe hepatic impairment (Child-Pugh ≥10)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<b>CHART NOTES ARE REQUIRED WITH THIS REQUEST</b>			
Prescriber Signature	Prescriber Specialty	Date	