## Rexulti<sup>®</sup> Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			<b>Provider Information</b> (required)			
Member Name:			Provider Name:			
Insurance ID#:			NPI#: Specialty:			
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	ZIP:	Office Street Address:			
Phone:			City:	State:	2	ZIP:
Medication Information (required)						
Medication Name:			Strength:		Dosage Form:	
			Directions for	Use:	1	
Clinical Information (required)						
1. Is Rexulti being used as adjunctive treatment for major depressive disorder?					🗆 Yes 🗖 No	
2. Has the patient tried an agent from at least two of the following classes for at least four weeks each: selective serotonin reuptake inhibitors (SSRIs), serotonin norepinephrine reuptake inhibitors (SNRIs), buspirone, bupropion or mirtazapine?					🗆 Yes 🗖 No	
3. Has the patient tried augmented therapy with an SSRI or SNRI plus either buspirone, bupropion or mirtazapine for at least four weeks?					🗆 Yes 🗅 No	
4. Has documentation of the use of objective, quantitative rating scales to monitor clinical status (e.g., Abnormal Involuntary Movement Scale [AIMS], Structured Clinical Interview for DSM-IV Axis I Disorders [SCID], Brief Psychiatric Rating Scale [BPRS], Positive and Negative Syndrome Scale [PANSS]) been submitted? [If yes, please submit documentation:]					S Yes No	

Information on this form is accurate as of this date.

Prescriber's Signature:	Date:

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note:	This request may be denied unless all required information is received.				
	For more information about the prior authorization process, please contact us at 855-811-2218.				
	Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern				

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