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.

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? ☐ Yes ☐ No

   If yes, is patient is adherent and stabilized on the requested dose? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:

   ☐ Bipolar I Disorder, acute mixed or manic episodes
   ☐ Depressed bipolar I disorder
   ☐ Schizophrenia
   ☐ 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)

   ☐ Aripiprazole ☐ Asenapine ☐ Clozapine ☐ Fluoxetine
   ☐ Iloperidone ☐ Lurasidone ☐ Olanzapine ☐ Paliperidone
   ☐ Quetiapine ☐ Risperidone ☐ Ziprasidone
   ☐ Olanzepine + fluoxetine ☐ Other. Specify:

4. Does patient have severe renal impairment (CrCl <30mL/min)? ☐ Yes ☐ No

5. Does patient have severe hepatic impairment (Child-Pugh ≥10)? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber Signature	Prescriber Specialty	Date