Rexulti (brexpiprazole)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Major depresive disorder(MDD) □ Schizophrenia □ **A**gitation associated with dementia due to Alzheimer's disease	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Major depressive disorder:

Does the patient have a diagnosis of major depressive disorder? □ Yes □ No

Has patient had a diagnosis of major depressive disorder for at least 24months? □ Yes □ No *Please submit documentation.*

Has patient been treated for their major depressive disorder with a minumum of 4 different antidepressants for a minimum of 6 weeks per drug regimen? □ Yes □ No *Please submit documentation.*

Is patient unable to reach a 50% improvement in their depressive symptoms? □ Yes □ No *Please submit documentation.*

Does patient have another psychiatric diagnosis? □ Yes □ No *Please submit documentation.*

Does patient have an eating disorder? □ Yes □ No *Please submit documentation.*

Does patient have substance use disorder? □ Yes □ No *Please submit documentation.*

Will patient continue to use Rexulti(brexipiprazole) in combination with another antidepressant? □ Yes □ No *Please submit documentation.*

Schizophrenia:

Does the patient have a diagnosis of schizophrenia?□ Yes □ No

Has the patient previously tried Abilify (aripiprazole)? □ Yes □ No *Please submit documentation.*

Agitation associated with dementia due to Alzheimer's disease:

Does patient have a Mini-Mental State Exam score of 5 to 22, inclusive, prior to starting Rexuluti(brexpiprazole)? □ Yes □ No

Please submit documentation.

Has patient had symptoms of agitation for at least 1 weeks prior to starting Rexulti(brexpiprazole)? □ Yes □ No

Please submit documentation.

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Does patient have a score of greater than or equal to 4 on the agitation/aggression item of the Neuropsychiatric Inventory-Nursing Home Scale(documentation required)? □ Yes □ No *Please submit documentation.*

Have all other causes for the patient's agitation been ruled out, such as pain, infection, polypharmacy? □ Yes □ No

Does patient have a history of bipolar-disorder or a psychotic disorder not related to dementia? □ Yes □ No

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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