



**Independence  
Blue Cross**

**Prior Authorization Form**

**Invega®/Seroquel XR®**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested:  Invega®  Seroquel XR®

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**\*\*\*MEDICARE PART D ONLY: REQUESTS FOR OFF-LABEL USE REQUIRE SUPPORTING LITERATURE\*\*\***

**1. DIAGNOSIS FOR DRUG REQUESTED:**

- Schizophrenia
- Bipolar disorder
- Other (specify) \_\_\_\_\_

**2. MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

**3. PATIENT HISTORY**

**a. Has the patient tried and failed or has a contraindication to any of the following?**

- Arapiprazole (Abilify®)  Yes  No
- Risperidone (Risperdal®)  Yes  No
- Quetiapine fumarate immediate release (Seroquel®)  Yes  No
- Olanzapine containing product  Yes  No

**b. Has the patient been stabilized in an institutional setting?**  Yes  No

**c. Is the patient currently stabilized?**  Yes  No

Please add any other supporting medical information that may be useful in the decision-making process:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**

<b>Internal use only</b>	<b>Coverage effective date</b> / /
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M F Rx coverage Y N	STANDARD - SELECT LOB _____
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