Prescriber Criteria Form Caplyta 2024 PA Fax 4531-A v2 010124.docx Caplyta (lumateperone) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Caplyta (lumateperone).

Drug Name: Caplyta (lumateperone)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of schizophrenia? [If no, then skip to question 4.]	Yes	No
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) lurasidone, D) olanzapine, E) quetiapine, F) risperidone, G) ziprasidone? [If no, then no further questions.]	Yes	No
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following brand products: A) Rexulti, B) Secuado, C) Vraylar? [No further questions.]	Yes	No
4	Is the requested drug being prescribed for the treatment of depressive episodes associated with bipolar I? [If no, then skip to question 7.]	Yes	No
5	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have contraindication to one of the following generic products: A) lurasidone, B) olanzapine, C) quetiapine? [If no, then no further questions.]	Yes	No

6	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to brand Vraylar? [No further questions.]	Yes	No
7	Is the requested drug being prescribed for the treatment of depressive episodes associated with bipolar II? [If no, then no further questions.]	Yes	No
8	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to generic quetiapine?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____