PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**
☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)
Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Fanapt® (Iloperidone)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Fanapt tablet
(1mg, 2mg, 4mg, 6mg, 8mg, 10mg, 12mg)
☐ Fanapt Titration Pack

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Drug cost information

The wholesale acquisition cost for Fanapt at a maximum dose of 12mg twice daily is approximately $2,505 per month. The annual cost of treatment with this drug will vary depending on the patient's circumstances, but may approach $30,060

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements (with supporting documentation):

1. Diagnosis of schizophrenia
2. 18 years of age or older
3. Have tried two of the following for 28 days each with clinical failure: olanzapine, quetiapine (either immediate release or extended release), risperidone, ziprasidone, aripiprazole
4. Must not be used in combination with other atypical antipsychotics

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2020
Last reviewed 07/2020

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Schizophrenia
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Is the patient at least 18 years of age?

- ☐ Yes
- ☐ No

C. The patient has tried the following for at least 28 days each:

	Dose	Dates	Outcome
☐ olanzapine			
☐ quetiapine			
☐ risperidone			
☐ ziprasidone			
☐ aripiprazole			

☐ Not all requirements are met – Below is rationale for use:

_____

D. Will Fanapt be used in combination with another atypical antipsychotic?

- ☐ Yes
- ☐ No

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2020
Last reviewed 07/2020