



Department of Vermont Health Access
 312 Hurricane Lane, Suite 201
 Williston, Vermont 05495

QUETIAPINE.2
 FORM#22
 R: 1.15

Agency of Human Services

~QUETIAPINE~

Prior Authorization Request Form

Vermont Medicaid has established criteria for prior authorization of quetiapine when used in doses of **50 mg/day or less**. In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Goold Health Systems. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information.

Submit request via: Fax: 1-844-679-5366 or Phone: 1-844-679-5363

Prescribing physician:

Beneficiary:

Name: _____
 Physician NPI: _____
 Phone#: _____
 Fax#: _____
 Address: _____
 Contact Person at Office: _____

Name: _____
 Medicaid ID#: _____
 Date of Birth: _____ Sex: _____
 Pharmacy Name _____
 Pharmacy NPI: _____
 Pharmacy Phone: _____ Pharmacy Fax: _____

Request is for: Quetiapine _____ mg (strength) _____ (frequency/directions for use)

Patient Clinical Information to Support Quetiapine Prior Authorization Request

- Indication for use is schizophrenia Indication for use is bipolar disorder
- Indication for use is adjunct treatment of major Depressive Disorder (MDD)

Patient initiated therapy with quetiapine for this indication on ___ / ___ / ___

Patient has responded inadequately to antidepressants listed below (at least 3 from 2 different classes):

Medication Name and Dose	Dates
_____	___ / ___ / ___
_____	___ / ___ / ___
_____	___ / ___ / ___

- Indication for use us an anxiety disorder

Patient initiated therapy with quetiapine for this indication on ___ / ___ / ___

Patient has responded inadequately to the antidepressants list below (at least 3 from 2 different classes):

Medication Name and Dose	Dates
_____	___ / ___ / ___
_____	___ / ___ / ___
_____	___ / ___ / ___

Or two antidepressants above and buspirone (dates:) _____

- Indication for use is another mental health disorder (not approved for insomnia)

Please specify _____ Date quetiapine was initiated for this indication ___ / ___ / ___

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescriber Signature: _____ Date of request: _____

