VERMONT
Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~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 Change Healthcare. Please complete this form in its entirety, sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare help desk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:

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

Beneficiary:

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)

If requesting Quetiapine XR, has the patient had an unsuccessful attempt with the IR formulation? ☐ Yes ☐ No
If not, please include clinical reasoning for therapy choice: _____

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 (include 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: _____

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