

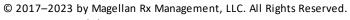
Latuda (Lurasidone) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME:		MEMBER'S FIRST NAME	i:	
mportant for the review (e.		to support the authorization re	additional documentation that is equest). Information contained in	
ins form is i folected fleat	Timormation under tim AA.		☐ URGENT	
MEMBER INFORMATION				
LAST NAME:		FIRST NAME:		
PHONE NUMBER:		DATE OF BIRTH:		
STREET ADDRESS:				
CITY:		STATE: ZIP CO	DE:	
PATIENT INSURANCE ID N	UMBER:	-		
F YOU ARE NOT THE PATIENT OR THE PRES OLLOWING LINK: <u>HTTPS://MAGELLANRX</u>	SCRIBER, YOU WILL NEED TO SUBMIT A PHI I	EIGHT (LB/KG): ALLI DISCLOSURE AUTHORIZATION FORM WITH THI /COMMON/DOC/EN-US/PHI DISCLOSURE A	IS REQUEST WHICH CAN BE FOUND AT THE UTHORIZATION.PDF	
AUTHORIZED REPRESENTA	TIVE'S PHONE NUMBER:			
PRESCRIBER INFORMATION)N			
LAST NAME:		FIRST NAME:		
PRESCRIBER SPECIALTY:		EMAIL ADDRESS:	EMAIL ADDRESS:	
NPI NUMBER:		DEA NUMBER:		
PHONE NUMBER:		FAX NUMBER:		
STREET ADDRESS:				
CITY:		STATE: ZIP CO	STATE: ZIP CODE:	
REQUESTOR (if different than prescriber):		OFFICE CONTACT PERSO	OFFICE CONTACT PERSON:	
MEDICATION OR MEDICA	AL DISPENSING INFORMATION	ON		
MEDICATION NAME:				
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:	
☐ NEW THERAPY	☐ RENEWAL	IF RENEWAL: DATE THE	RAPY INITIATED:	
DURATION OF THERAPY (S	PECIFIC DATES):			

Continued on next page.



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MEMBER'S LAST NAME:	MEMBER'S FIRST NAME:			
1. HAS THE PATIENT TRIED ANY OTHE	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:		
2. LIST DIAGNOSES:		ICD-10:		
 □ Depressive episode associated with Bi □ Schizophrenia □ Other diagnosis: 				
3. REQUIRED CLINICAL INFORMATION PRIOR AUTHORIZATION.	N: PLEASE PROVIDE ALL RELEVANT CLIN	ICAL INFORMATION TO SUPPORT A		
Has the patient had a trial and failure Please provide chart documentation Has the patient had a trial and failure Please provide chart documentation Has the patient had a trial and failure Please provide chart documentation Schizophrenia: Has the patient tried and failed at least Clozaril (clozapine), etc.]?	e of Symbyax (olanzapine/fluoxetine)? specifying dates of service. e of Seroquel (quetiapine)? specifying dates of service. st 3 different antipsychotics [e.g., Abilify	□ Yes □ No No y (aripiprazole), Navane (thiothixene),		
Has the patient tried the generic lura	sidone product? □ Yes □ No			
Does patient have an absolute contra chart notes.	indication to the generic lurasidone?	□ Yes □ No *Please provide supporting		
-	d generic lurasidone and will not be cone drug reactions (FDA Form 3500) beer pleted FDA 3500 form.			
Are there any other comments, diagn physician feels is important to this re	oses, symptoms, medications tried or faview?	illed, and/or any other information the		

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Please note: Not all drugs/diagnosis are covered on	all plans. This request may be denied unless all required	
information is received.		

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: Date:

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP – 4201 P.O. Box 64811 St. Paul, MN 55164-0811

Magellan Rx MANAGEMENTS