Prior Authorization Request Form for
lumateperone **(Caplyta)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **Is the patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. **Does the patient have a diagnosis of schizophrenia? Note: Non-FDA approved uses are NOT approved including sleep disorders, depression, and other neuropsychiatric and neurological disorders.**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **Has the patient tried and failed at least TWO formulary atypical antipsychotics (for example risperidone, aripiprazole, lurasidone, quetiapine)?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Is the requested medication prescribed by or in consultation with a psychiatrist?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.**
Please sign and date:

_____ _____
Prescriber Signature Date

[05 August 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: