**OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.**
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Seroquel XR® (quetiapine extended-release [ER]) Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

## Member Information (required)

| | | |
|---|---|---|
| Member Name: | | |
| Insurance ID#: | | |
| Date of Birth: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | | |

## Provider Information (required)

| | | |
|---|---|---|
| Provider Name: | | |
| NPI#: | Specialty: | |
| Office Phone: | | |
| Office Fax: | | |
| Office Street Address: | | |
| City: | State: | Zip: |

## Medication Information (required)

| | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Continuation of therapy:**

Is this a continuation of prior therapy within the past 120 days? ❑ **Yes** ❑ **No**

**Select the diagnosis below:**

- ❑ Bipolar disorder, depressive episodes
- ❑ Bipolar I disorder maintenance (adjunct to lithium or divalproex)
- ❑ Bipolar I disorder, manic or mixed episodes
- ❑ Major depressive disorder (adjunctive treatment)
- ❑ Schizophrenia
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Select the medications the patient has a failure, contraindication, or intolerance to:**

- ❑ Aripiprazole
- ❑ Aripiprazole orally disintegrating tablet (ODT)
- ❑ Fanapt
- ❑ Fanapt Titration Pack
- ❑ Latuda
- ❑ Olanzapine
- ❑ Olanzapine ODT
- ❑ Paliperidone ER
- ❑ Quetiapine
- ❑ Quetiapine ER
- ❑ Rexulti
- ❑ Risperidone
- ❑ Risperidone ODT
- ❑ Saphris
- ❑ Vraylar
- ❑ Ziprasidone

**Quantity limit requests:**

What is the quantity requested per DAY? _____

**What is the reason for exceeding the plan limitations?**

- ❑ Titration or loading-dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
- ❑ Other: _____

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.