Prescriber Criteria Form Opipza 2025 PA Fax 6754-A v1 020125.docx Opipza (aripiprazole) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Opipza (aripiprazole).

Drug Name: Opipza (aripiprazole)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of schizophrenia? [If no, then skip to question 5.]	Yes ◯	No ◯
2	Is the patient unable to swallow oral formulations? [If yes, then no further questions.]	Yes ◯	No ◯
3	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following generic products: A) aripiprazole, B) asenapine, C) lurasidone, D) olanzapine, E) quetiapine, F) risperidone, G) ziprasidone? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following brand products: A) Caplyta, B) Lybalvi, C) Rexulti, D) Secuado, E) Vraylar? [No further questions.]	Yes ◯	No ◯
5	Is the requested drug being prescribed for adjunctive treatment of major depressive disorder (MDD)? [If no, then skip to question 9.]	Yes ◯	No ◯
6	Is the patient unable to swallow oral formulations? [If yes, then no further questions.]	Yes ◯	No ◯

7	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following generic products: A) aripiprazole, B) olanzapine, C) quetiapine? [If no, then no further questions.]	Yes ◯	No ◯
8	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following brand products: A) Rexulti, B) Vraylar? [No further questions.]	Yes ◯	No ◯
9	Is the requested drug being prescribed for the treatment of irritability associated with autistic disorder? [If no, then skip to question 12.]	Yes ◯	No ◯
10	Is the patient unable to swallow oral formulations? [If yes, then no further questions.]	Yes ◯	No ◯
11	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to one of the following generic products: A) aripiprazole, B) risperidone? [No further questions.]	Yes ◯	No ◯
12	Is the requested drug being prescribed for the treatment of Tourette's disorder? [If no, then no further questions.]	Yes ◯	No ◯
13	Is the patient unable to swallow oral formulations? [If yes, then no further questions.]	Yes ◯	No ◯
14	Has the patient experienced an inadequate treatment response or intolerance to generic aripiprazole?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____