US Family Health Plan
Prior Authorization Request Form for lumateperone (**Caplyta**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

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. What is the indication or diagnosis? Note: Non-FDA approved uses are NOT approved including sleep disorders, depression, and other neuropsychiatric and neurological disorders.	☐ Schizophrenia - Proceed to question **4** ☐ Depressive episodes associated with bipolar disorder I or II - Proceed to question **3** ☐ Other – **STOP** **Coverage not approved**	
3. Will the requested medication be used as monotherapy or as adjunct to lithium or valproate?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed at least TWO formulary atypical antipsychotics (for example risperidone, aripiprazole, lurasidone, quetiapine)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. 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

[29 June 2022]