



Date \_\_\_\_\_

# PRIOR AUTHORIZATION QUESTIONNAIRE – quetiapine (Seroquel® IR)

<b>Prescriber Last Name:</b> _____	<b>Prescriber First Name:</b> _____
<b>Prescriber Phone:</b> _____	<b>Prescriber Fax:</b> _____
<b>Patient</b> _____	<b>ID#</b> _____ <b>DOB</b> _____

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN A DELAY OR AN AUTOMATIC DENIAL\*\***

1. Diagnosis:

- |  |   |
|--|---|
| <input type="checkbox"/> Schizophrenia                 | <input type="checkbox"/> Schizoaffective Disorder                       |
| <input type="checkbox"/> Bipolar Disorder              | <input type="checkbox"/> Adjunctive Treatment Major Depressive Disorder |
| <input type="checkbox"/> Other (please specify): _____ |   |

2. Patient's age: \_\_\_\_\_

3. Requested dose: \_\_\_\_\_

4. Has the patient been diagnosed with dementia-related psychosis? Yes    No

**For diagnosis of Schizophrenia, Schizoaffective Disorder, and Bipolar disorder, skip to Question #7**

5. Is the patient currently stable on the medication? Yes    No

a. If Yes, provide the date therapy was initiated \_\_\_\_\_

6. List and provide dates of trial of other antidepressant therapies that the patient has failed or been intolerant to:

\_\_\_\_\_

7. Prescriber signature or name and title of staff member providing answers \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

Restat  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:  
**877-526-9906**

[www.restat.com](http://www.restat.com)

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Date: 4/18/2013