restat
a Catamaran company

Date _____

PRIOR AUTHORIZATION QUESTIONNAIRE – quetiapine (Seroquel® IR)

Prescriber Last Name:_____ ***Prescriber First Name:***_____

Prescriber Phone: _____ ***Prescriber Fax:*** _____

Patient _____ ***ID#***_____***DOB*** _____

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

1. Diagnosis:

☐ Schizophrenia ☐ Schizoaffective Disorder

☐ Bipolar Disorder ☐ Adjunctive Treatment Major Depressive Disorder

☐ 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

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QUESTIONS PLEASE CALL:
877-526-9906