DRUG PRIOR AUTHORIZATION
SAPHRIS (ASENAPINE)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
DATE:	PRESCRIBER FIRST & LAST NAME:
PATIENT LAST NAME:	PRESCRIBER NPI:
PATIENT FIRST NAME:	PRESCRIBER SPECIALTY:
PATIENT ID:	PRESCRIBER PHONE:
PATIENT BIRTH DATE:	PRESCRIBER FAX:
PATIENT GENDER: MALE FEMALE	CONTACT PERSON:

STEP 2: MEDICATION HISTORY

MEDICATION REQUESTED:

SAPHRIS ☐ **5MG** ☐ **10MG** QUANTITY:______________ PER MONTH (TWICE DAILY DOSING RECOMMENDED)

DIAGNOSIS (CHOOSE ONE):

- ☐ **SCHIZOPHRENIA**
- ☐ **BIPOLAR I DISORDER**
- ☐ **OTHER** :____

PATIENT TRIED AND FAILED IN THE PREVIOUS 4 MONTHS (A MINIMUM OF 2 MEDICATIONS IS REQUIRED):

☐ **ABILIFY** TRIAL DATES: __________ TO ____________
REASON FOR DISCONTINUATION: ____

☐ **GEODON** TRIAL DATES: __________ TO ____________
REASON FOR DISCONTINUATION: ____

☐ **RISPERIDONE (RISPERDAL)** TRIAL DATES: __________ TO ____________
REASON FOR DISCONTINUATION: ____

☐ **SEROQUEL (XR)** TRIAL DATES: __________ TO ____________
REASON FOR DISCONTINUATION: ____

☐ **ZYPREXA** TRIAL DATES: __________ TO ____________
REASON FOR DISCONTINUATION: ____

STEP 3: COMPLETE AND FAX TO: COLORADO ACCESS PRIOR AUTHORIZATION **720-744-5127**
PRESCRIBER SIGNATURE:
FOR QUESTIONS: COLORADO ACCESS CUSTOMER CARE AT 303-751-9005 OR 800-511-5010
IF PATIENT MEETS CRITERIA- ALLOW 2 BUSINESS DAYS FOR PROCESSING
IF CRITERIA NOT MET- SUBMIT CHART DOCUMENTATION WITH FORM CITING COMPLEX MEDICAL CIRCUMSTANCES
IF APPROVED, COVERAGE ALLOWED FOR: LIFETIME SUBJECT TO FORMULARY CHANGES