Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

Vraylar™ (cariprazine)

Review Criteria

Member must meet all the following criteria:

- Subject to Preferred Drug List requirements
- Member must have diagnosis of either schizophrenia or bipolar I
    - Diagnosis of schizophrenia:
        - Member must have an inadequate response or have been intolerant to at least 2 preferred atypical antipsychotic agents at maximally tolerated dose and duration (refer to Preferred Drug List for preferred options).
    - Diagnosis of bipolar I:
        - Member must have had an inadequate response or been intolerant to at least 2 preferred atypical antipsychotic agents at maximally tolerated dose and duration (refer to Preferred Drug List for preferred options).

Limitations:

- Maximum daily dose allowed is 1.0