UnitedHealthcare Community Plan

Abilify
PRIOR AUTHORIZATION REQUEST FORM

Please complete this entire form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form contains multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: ________________
Is this patient currently hospitalized? □ Yes □ No

Section B - Physician Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Dispense as Written: □ **Yes** □ **No**	
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? □ **Yes** □ **No** **If yes, what is this member's due date?** ________________	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information about this case, if any:

Clinical and Drug Specific Information

- What is the patient's diagnosis?
□ Schizophrenia □ Schizoaffective disorder □ Bipolar disorder □ Autism □ Major depressive disorder
□ Tourette's □ Other, list diagnosis: ____

Requests for Schizophrenia, Schizoaffective Disorder or Bipolar

- Does the patient have a history of failure, contraindication, or intolerance to any of the following: □ Yes □ No
□ Quetiapine immediate release □ Risperidone tablets □ Ziprasidone capsule □ Olanzapine tablet
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

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Requests for diagnosis of Autism:

- **Does the patient have a history of failure, contraindication, or intolerance to risperidone tablet? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, duration, and date of trial)

Requests for diagnosis of Major Depressive Disorder:

- **Does the patient have an already established antidepressant therapy? □ Yes □ No**
  If yes, list therapy: ____

- **Will Abilify be used as adjuctive (added on to) therapy to the antidepressant treatment? □ Yes □ No**

Requests for Continuation of Therapy:

- **Is the patient currently stable on the requested medication? □ Yes □ No**

- **Is the patient currently receiving treatment with the requested medication in the hospital and must continue upon discharge? □ Yes □ No**

Requests for Other Failed Treatment Modalities:

- **Is the patient unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modifications attempted)? □ Yes □ No**
  If yes, list other treatment modalities and dates: ____
  ____

- **Has the patient tried and failed all available preferred atypical antipsychotics that are FDA approved for the patient's age? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, duration, and date of trial)

- **Does the child display symptoms of aggression as a symptom of developmental delay, autism, Tourette's syndrome or chronic tics, oppositional defiant disorder, or conduct disorder? □ Yes □ No**
  If yes, list reason for symptoms of aggression: ____
  ____

Quantity limit requests:

(Abilify tablet quantity limit = 1 tablet per day up to a maximum of 30mg per day unless half tablet regimen is required)

- **Is there a reason why a greater quantity of medication is required to treat the patient's condition? □ Yes □ No**
  If yes, list reasoning: ____
  ____

- **Is there a reason or special circumstance that the patient cannot use a half tablet regimen if required? □ Yes □ No**
  If yes, list reasoning: ____
  ____

Therapeutic Duplication requests:

- **Is the Abilify being used to adjust the dose of the drug? □ Yes □ No**

- **Is Abilify being used in place of the previous antipsychotic, and <u>not in addition</u> to it? □ Yes □ No**

- **Is the requested dosage form being used in place of the previous antipsychotic dosage form, and not in addition to it? □ Yes □ No**

- **Is there a reason or special circumstance that the patient will be taking two or more atypical antipsychotics?**
  □ Yes □ No If yes, list reason: ____

Physician Signature: ______________________________ **Date:** ______________

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