

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain 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 Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider 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:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
 Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have any of the following diagnoses? <i>(If yes, check which applies)</i> <input type="checkbox"/> Attention-deficit hyperactivity disorder (ADHD) <input type="checkbox"/> Nausea and or vomiting <input type="checkbox"/> Autism <input type="checkbox"/> Psychosis <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Schizophrenia or schizoaffective disorder <input type="checkbox"/> Generalized anxiety disorder <input type="checkbox"/> Tourette's <input type="checkbox"/> Major depressive disorder
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge? <i>If yes, list start date and discharge date:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient demonstrated failure or intolerance to a majority of the preferred formulary/preferred drug list (PDL) alternatives for the given diagnosis, which sufficiently demonstrates that the alternatives are either ineffective or inappropriate at the time of the request? <i>(If yes, please complete Section D above)</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	If requesting an injectable, is the patient non-adherent with oral atypical antipsychotic dosage forms? <i>(If yes, please complete Section D above)</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	If requesting an injectable, is the patient unable to take oral solid alternatives? <i>If yes, list reason:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	If requesting a multi-source brand medication, does the patient meet any of the following? <i>(If yes, check which applies)</i> <input type="checkbox"/> The multi-source brand is being requested because of an adverse reaction, allergy, or sensitivity to a generic equivalent <input type="checkbox"/> The multi-source brand is being requested due to a therapeutic failure with the generic equivalent <input type="checkbox"/> The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient <input type="checkbox"/> Special clinical circumstances exist that preclude the use of a generic version of the brand medication for the patient
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FOR PATIENTS UNDER THE FDA APPROVED AGE

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient unresponsive to other treatment modalities, unless contraindicated (i.e., other medications or behavioral modification attempted)? <i>If yes, list other treatment modalities and dates:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient tried and failed all available preferred atypical antipsychotics that are FDA approved for the patient's age? <i>(If yes, complete Section D above)</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient display symptoms of aggression as a symptom of developmental delay, autism, Tourette's syndrome or chronic tics, oppositional defiant disorder, or conduct disorder?
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ABILIFY MAINTENA / ARISTADA

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient established tolerability with oral aripiprazole?
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INVEGA SUSTENNA

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient established tolerability with oral paliperidone or oral risperidone?
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INVEGA TRINZA

<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient been treated with Invega Sustenna for at least 4 months?
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LATUDA

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a diagnosis of depressive episodes associated with Bipolar I Disorder (bipolar depression)?
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<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes to the above, does the patient have a history of failure, contraindication, or intolerance to any of the following? <i>(If yes, check which applies and complete Section D above)</i> <input type="checkbox"/> Fluoxetine used in combination with olanzapine <input type="checkbox"/> Quetiapine
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Member First name:		Member Last name:		Member DOB:							
PERSERIS / RISPERDAL CONSTA											
<input type="checkbox"/> Yes <input type="checkbox"/> No		Has the patient established tolerability with oral risperidone?									
RISPERDAL ORAL SOLUTION											
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is the patient unable to swallow the oral solid preferred alternatives?									
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a history of failure, contraindication, or intolerance to a majority of the oral solid preferred alternatives? <i>(If yes, please complete Section D above)</i>									
ABILIFY MYCITE											
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will medical records documenting the patient is currently prescribed aripiprazole and tolerates the medication be submitted? <i>(DOCUMENTATION REQUIRED)</i>									
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will medical records documenting the patient's adherence to aripiprazole is less than 80% within the past 6 months be submitted? <i>(DOCUMENTATION REQUIRED)</i> <i>NOTE: Medication adherence percentage is defined by the number of pills absent in a given time period divided by the number of pills prescribed during that same time, multiplied by 100</i>									
<input type="checkbox"/> Yes <input type="checkbox"/> No		Have all of the following strategies (if applicable to patient) to improve patient adherence been tried without success? <ul style="list-style-type: none"> • Utilization of a pill box. • Utilization of a smart phone reminder (ex. alarm, application, or text reminder). • Involving family members or friends to assist. • Coordinating timing of dose to coincide with dosing of another daily medication. 									
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will medical records documenting patient has experienced life-threatening or potentially life-threatening symptoms, or has experienced a severe worsening of symptoms leading to a hospitalization which was attributed to the lack of adherence to aripiprazole be submitted? <i>(DOCUMENTATION REQUIRED)</i>									
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the patient have a history of failure, contraindication, intolerance or reason or special circumstance they cannot use any of the following? <i>(If yes, check which applies and complete Section D above)</i> <table border="0" style="width: 100%; margin-top: 5px;"> <tr> <td><input type="checkbox"/> Abilify Maintena</td> <td><input type="checkbox"/> Perseris</td> </tr> <tr> <td><input type="checkbox"/> Aristada</td> <td><input type="checkbox"/> Risperdal Consta</td> </tr> <tr> <td><input type="checkbox"/> Invega Sustenna</td> <td></td> </tr> </table>				<input type="checkbox"/> Abilify Maintena	<input type="checkbox"/> Perseris	<input type="checkbox"/> Aristada	<input type="checkbox"/> Risperdal Consta	<input type="checkbox"/> Invega Sustenna	
<input type="checkbox"/> Abilify Maintena	<input type="checkbox"/> Perseris										
<input type="checkbox"/> Aristada	<input type="checkbox"/> Risperdal Consta										
<input type="checkbox"/> Invega Sustenna											
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the prescriber acknowledge that Abilify MyCite has not been shown to improve patient adherence and attests that Abilify MyCite is medically necessary for the patient to maintain compliance, avoid life-threatening worsening of symptoms, and reduce healthcare resources utilized due to lack of adherence?									
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the prescriber agree to track and document adherence to Abilify MyCite through software provided by the manufacturer?									
CONTINUATION OF THERAPY - ABILIFY MYCITE											
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there documentation the patient is clinically stable on Abilify MyCite?									
<input type="checkbox"/> Yes <input type="checkbox"/> No		Will medical records documenting that the use of Abilify MyCite has increased adherence to 80% or more be submitted? <i>(DOCUMENTATION REQUIRED)</i>									
<input type="checkbox"/> Yes <input type="checkbox"/> No		Does the prescriber attest that the patient requires the continued use of Abilify MyCite to remain adherent?									
QUANTITY LIMIT - CAPLYTA											
<input type="checkbox"/> Yes <input type="checkbox"/> No		Is there rationale for needing to exceed the quantity limit of one capsule (42mg) per day? <i>If yes, list rationale:</i>									

Provider Signature: _____ **Date:** _____

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