UnitedHealthcare Community Plan

Abilify - Ohio

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 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: □ New or □ Continuation of Therapy? If continuation, list start date: _______________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _________________

Section B - Provider Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	**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? □ Yes □ 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 for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
☐ Yes ☐ No	**Does the patient have any of the following diagnoses? (check which applies)** ☐ Schizophrenia ☐ Schizoaffective disorder ☐ Bipolar disorder ☐ Autism ☐ Major depressive disorder ☐ Tourette's
SCHIZOPHRENIA, SCHIZOAFFECTIVE DISORDER, AND BIPOLAR	
☐ Yes ☐ No	**Does the patient have a history of failure, contraindication, or intolerance to any of the following preferred alternatives? (check all that apply and complete Section D)** ☐ **Quetiapine IR Tablet** ☐ **Risperidone Tablet** ☐ **Ziprasidone Capsule** ☐ **Olanzapine Tablet**
DIAGNOSIS OF AUSTISM	
☐ Yes ☐ No	**Does the patient have a history of failure, contraindication, or intolerance to risperidone tablet?** *If yes, list medications tried, dates of therapy and reasons for discontinuation:*
DIAGNOSIS OF MAJOR DEPRESSIVE DISORDER	
☐ Yes ☐ No	**Does the patient have an already established antidepressant therapy?** *If yes, list therapy:*
☐ Yes ☐ No	**Will Abilify be used as adjunct (added on to) therapy to antidepressant treatment?**
LESS THAN THE FDA APPROVED MINIMUM AGE	
☐ Yes ☐ No	**Is the patient unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modifications attempted)?** *If yes, list other treatment modalities and dates:*
☐ Yes ☐ No	**Has the patient tried and failed all available preferred atypical antipsychotics that are FDA approved for the patient's age?** *(If yes, complete Section D)*
☐ Yes ☐ No	**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?** *If yes, list reason for symptoms of aggression:*
QUANTITY LIMIT *Please note: Ability tablet quantity limit = 1 tablet per day up to a maximum of 30mg per day.*	
☐ Yes ☐ No	**Is there a reason why a greater quantity of medication is required to treat the patient's condition?** *If yes, list reasoning:*

Provider Signature: ____ **Date:** ____________________

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