UnitedHealthcare Community Plan

Abilify – Rhode Island
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:

- What is the patient's diagnosis? (check which applies)

□ Schizophrenia □ Schizoaffective disorder □ Bipolar disorder
□ Autism □ Major depressive disorder □ Tourette's
□ **Other, list diagnosis:** _____

- Does the patient meet either of the following: □ Yes □ No (check which applies)

□ The patient is currently stable on the requested medication
□ The patient is currently receiving treatment with the requested medication in the hospital and must continue upon discharge

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, date of trial, and reason for discontinuation)

Requests for AUSTIM:

- 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, date of trial, and reason for discontinuation)

Requests for MAJOR DEPRESSIVE DISORDER:

- Does the patient have an already established antidepressant therapy? □ Yes □ No

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

Requests for AGE LIMIT:

- 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, date of trial, and reason for discontinuation)

- 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: _____
_____

Requests for QUANTITY LIMITS:

(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: _____

Provider Signature: _____ **Date:** _____