UnitedHealthcare Community Plan

Antipsychotics – 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:
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? □ 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 at www.uhcprovider.com 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?** *(If yes, check which applies)* □ Schizophrenia or Schizoaffective Disorder □ Bipolar Disorder □ Autism Spectrum Disorder □ Major Depressive Disorder □ Tourette's Syndrome
□ **Yes** □ **No**	**Is the patient unable to take oral solid alternatives?** *If yes, list reason:*
□ **Yes** □ **No**	**Is the patient currently on the requested drug?** *If yes, list start date:*
□ **Yes** □ **No**	**Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?** *If yes, list start date and discharge date:*
□ **Yes** □ **No**	**If requesting an injectable, is the patient non-compliant with oral atypical antipsychotic dosage forms?** *(If yes, please complete Section D above)*
RISPERDAL CONSTA & PERSERIS	
□ **Yes** □ **No**	**Has the patient established tolerability with oral risperidone?** *If yes, list dates:*
INVEGA SUSTENNA	
□ **Yes** □ **No**	**Has the patient established tolerability with oral paliperidone or oral risperidone?** *If yes, list medication and dates:*
INVEGA TRINZA	
□ **Yes** □ **No**	**Has the patient been treated with Invega Sustenna for at least 4 months?** *If yes, list dates:*
ABILIFY MAINTENA / ARISTADA	
□ **Yes** □ **No**	**Has the patient established tolerability with oral aripiprazole?** *If yes, list dates:*
ORAL ANTIPSYCHOTICS FOR MEMBERS UNDER THE FDA APPROVED AGE	
□ **Yes** □ **No**	**Is the patient unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modification 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 above)*
□ **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:*
ABILIFY MYCITE ***(continued on next page)***	
□ **Yes** □ **No**	**Is there submission of medical records documenting the patient is currently prescribed aripiprazole and tolerates the medication?**
□ **Yes** □ **No**	**Is there submission of medical records documenting the patient's adherence to aripiprazole is less than 80% within the past 6 months? (NOTE: Medication adherence percentage is defined as the number of pills absent in a given time period divided by the number of pills prescribed during that same time, multiplied by 100.)** *If yes, list patient adherence percentage and date:*

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□ Yes □ No	**Have all of the following strategies (if applicable to patient) to improve patient adherence been tried without success?** • 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.
□ Yes □ No	**Is there submission of 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?** *If yes, list rationale:*
□ Yes □ No	**Does the patient have history of failure, contraindication, or intolerance or reason or special circumstance they cannot use any of the following?** *(If yes, complete Section D above)* □ Abilify Maintena □ Invega Sustenna □ Risperdal Consta □ Aristada □ Perseris
□ Yes □ 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?**
□ Yes □ No	**Does the prescriber agree to track and document adherence to Abilify MyCite through software provided by the manufacturer?**
CONTINUATION OF THERAPY – ABILIFY MYCITE	
□ Yes □ No	**Is there documentation the patient is clinically stable on Abilify MyCite?**
□ Yes □ No	**Is there submission of medical records documenting that the use of Abilify MyCite has increased adherence to 80% or more?** *If yes, list patient adherence percentage:*
□ Yes □ No	**Does the prescriber attest that the patient requires the continued use of Abilify MyCite to remain adherent?**

Provider Signature: _____ Date: _____