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

UnitedHealthcare Community Plan

Antipsychotics – Rhode Island
Prior Authorization Request Form

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)* □ Autism □ Bipolar disorder □ Major depressive disorder □ Schizophrenia or schizoaffective disorder □ Tourette's
□ **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**	**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?** *(If yes, please complete Section D above)*
□ **Yes** □ **No**	**If requesting an injectable, is the patient non-adherent with oral atypical antipsychotic dosage forms?** *(If yes, please complete Section D above)*
□ **Yes** □ **No**	**If requesting an injectable, is the patient unable to take oral solid alternatives?** *If yes, list reason:*
□ **Yes** □ **No**	**If requesting a multi-source brand medication, does the patient meet any of the following?** *(If yes, check which applies)* □ The multi-source brand is being requested because of an adverse reaction, allergy, or sensitivity to a generic equivalent □ The multi-source brand is being requested due to a therapeutic failure with the generic equivalent □ The multi-source brand is being requested because transition to a generic equivalent could result in destabilization of the patient □ Special clinical circumstances exist that preclude the use of a generic version of the brand medication for the patient
FOR PATIENTS 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 patient display symptoms of aggression as a symptom of developmental delay, Tourette's syndrome or chronic tics, oppositional defiant disorder, or conduct disorder?**
ABILIFY MAINTENA / ARISTADA	
□ **Yes** □ **No**	**Has the patient established tolerability with oral aripiprazole?**
INVEGA SUSTENNA	
□ **Yes** □ **No**	**Has the patient established tolerability with oral paliperidone or oral risperidone?**
INVEGA TRINZA	
□ **Yes** □ **No**	**Has the patient been treated with Invega Sustenna for at least 4 months?**
LATUDA	
□ **Yes** □ **No**	**Does the patient have a diagnosis of depressive episodes associated with Bipolar I Disorder (bipolar depression)?**
□ **Yes** □ **No**	**If yes to the above, does the patient have a history of failure, contraindication, or intolerance to any of the following?** *(If yes, check which applies and complete Section D above)* □ Fluoxetine used in combination with olanzapine □ Quetiapine

UnitedHealthcare Community Plan

Antipsychotics – Rhode Island
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

PERSERIS / RISPERDAL CONSTA	
□ **Yes** □ **No**	**Has the patient established tolerability with oral risperidone?**
RISPERDAL ORAL SOLUTION	
□ **Yes** □ **No**	**Is the patient unable to swallow the oral solid preferred alternatives?**
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, or intolerance to a majority of the oral solid preferred alternatives?** *(If yes, please complete Section D above)*
ABILIFY MYCITE	
□ **Yes** □ **No**	**Will medical records documenting the patient is currently prescribed aripiprazole and tolerates the medication be submitted?** (*DOCUMENTATION REQUIRED)*
□ **Yes** □ **No**	**Will medical records documenting the patient's adherence to aripiprazole is less than 80% within the past 6 months be submitted?** (*DOCUMENTATION REQUIRED)* *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*
□ **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**	**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?** (*DOCUMENTATION REQUIRED)*
□ **Yes** □ **No**	**Does the patient have a history of failure, contraindication, intolerance, or reason or special circumstance they cannot use any of the following?** *(If yes, check which applies and complete Section D above)* □ Abilify Maintena □ Perseris □ Aristada □ Risperdal Consta □ Invega Sustenna
□ **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**	**Will medical records documenting that the use of Abilify MyCite has increased adherence to 80% or more be submitted?** *(DOCUMENTATION REQUIRED)*
□ **Yes** □ **No**	**Does the prescriber attest that the patient requires the continued use of Abilify MyCite to remain adherent?**
QUANTITY LIMIT - CAPLYTA	
□ **Yes** □ **No**	**Is there rationale for needing to exceed the quantity limit of one capsule (42mg) per day?** *If yes, list rationale:*

Provider Signature: _____ **Date:** _____