UnitedHealthcare Community Plan

Antipsychotics
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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Clinical and Drug Specific Information

ALL REQUESTS

□ Yes □ No	**Does the patient have any of the following diagnoses?** *(If yes, check which applies)* □ Attention-deficit hyperactivity disorder (ADHD) □ Autism □ Bipolar disorder □ Generalized anxiety disorder □ Major depressive disorder □ Nausea and/or vomiting □ Psychosis □ Schizophrenia or schizoaffective disorder □ Tourette's
□ Yes □ No	**Has the patient been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan?**
□ 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 <u>failure</u> to a majority of the preferred formulary/preferred drug list (PDL) alternatives, one of which is aripiprazole, for the given diagnosis?** *(If yes, complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* * Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request
□ Yes □ No	**Has the patient demonstrated <u>intolerance</u> to a majority of the preferred formulary/PDL alternatives, one of which is aripiprazole, for the given diagnosis?** *(If yes, complete Section D above, including the intolerance)* * Prior trials of formulary/PDL alternatives must sufficiently demonstrate that the formulary/PDL alternatives are either ineffective or inappropriate at the time of the request
□ 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. *Specify the adverse reaction, allergy, or sensitivity:*_____ □ The multi-source brand is being requested due to a therapeutic failure with the generic equivalent. *MEDICAL RECORDS MUST BE SUBMITTED* □ 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 multi-source brand medication for the patient. *Document special clinical circumstances:*_____

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 / ARISTADA INITIO

□ Yes □ No	**Has the patient established tolerability with oral aripiprazole?**

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ABILIFY MYCITE	
□ Yes □ No	**Will medical records be submitted documenting the patient is currently prescribed aripiprazole and tolerates the medication?** (*DOCUMENTATION REQUIRED)*
□ Yes □ No	**Will medical records be submitted documenting the patient's adherence to aripiprazole is less than 80% within the past 6 months?** (*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 be submitted 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?** (*DOCUMENTATION REQUIRED)*
□ Yes □ No	**Does the patient have <u>failure</u> to any of the following?** *(If yes, check which applies and complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* □ Abilify Maintena □ Aristada □ Invega Sustenna □ Perseris □ Risperdal Consta
□ Yes □ No	**Does the patient have a history of <u>contraindication, intolerance, reason or special circumstance</u> why they cannot use any of the following?** *(If yes, check which applies and complete Section D above, including the contraindication, intolerance, reason or special circumstance)* □ Abilify Maintena □ Aristada □ Invega Sustenna □ Perseris □ Risperdal Consta
□ 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 of Abilify MyCite through software provided by the manufacturer?**
ABILIFY MYCITE - CONTINUATION OF THERAPY	
□ Yes □ No	**Is there documentation the patient is clinically stable on Abilify MyCite?**
□ Yes □ No	**Will medical records be submitted documenting that the use of Abilify MyCite has increased adherence to 80% or more?** *(DOCUMENTATION REQUIRED)*
□ Yes □ No	**Does the prescriber attest that the patient requires the continued use of Abilify MyCite to remain adherent?**
INVEGA HAFYERA	
□ Yes □ No	**Has the patient been established on once-a-month paliperidone palmitate extended-release injectable suspension (e.g., Invega Sustenna) for at least 4 months?**
□ Yes □ No	**Has the patient been established on every-three-month paliperidone palmitate extended-release injectable suspension (e.g., Invega Trinza) for at least one three-month cycle?**
INVEGA SUSTENNA	
□ Yes □ No	**Has the patient established tolerability with oral paliperidone or oral risperidone?**
INVEGA TRINZA	
□ Yes □ No	**Has the patient been established on Invega Sustenna for at least 4 consecutive months prior to initiating Invega Trinza?**

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	LATUDA
□ **Yes** □ **No**	**Does the patient have a diagnosis of schizophrenia or schizoaffective disorder?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to three preferred alternatives, one of which is aripiprazole?** *(If yes, complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)*
□ **Yes** □ **No**	**Does the patient have a history of <u>intolerance or contraindication</u> to three preferred alternatives, one of which is aripiprazole?** *(If yes, complete Section D above, including the intolerance or contraindication)*
□ **Yes** □ **No**	**Does the patient have a diagnosis of depressive episodes associated with Bipolar I Disorder (bipolar depression)?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to any of the following?** *(If yes, check which applies and complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* □ Fluoxetine used in combination with olanzapine □ Quetiapine
□ **Yes** □ **No**	**Does the patient have a history of <u>contraindication or intolerance</u> to any of the following?** *(If yes, check which applies and complete Section D above, including the contraindication or intolerance)* □ Fluoxetine used in combination with olanzapine □ Quetiapine
	PERSERIS / RISPERDAL CONSTA
□ **Yes** □ **No**	**Has the patient established tolerability with oral risperidone?**
	RISPERDAL / RISPERIDONE ORAL SOLUTION
□ **Yes** □ **No**	**Is the patient unable to swallow the oral solid preferred alternatives?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to a majority of the oral solid preferred alternatives?** *(If yes, complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)*
□ **Yes** □ **No**	**Does the patient have a history of <u>contraindication or intolerance</u> to a majority of the oral solid preferred alternatives?** *(If yes, complete Section D above, including the contraindication or intolerance)*
	VRAYLAR
□ **Yes** □ **No**	**Does the patient have a diagnosis of schizophrenia or schizoaffective disorder?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to three preferred alternatives, one of which is aripiprazole?** *(If yes, complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)*
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□ **Yes** □ **No**	**Does the patient have a history of <u>contraindication or intolerance</u> to any of the following?** *(If yes, check which applies and complete Section D above, including the contraindication or intolerance)* □ Fluoxetine used in combination with olanzapine □ Quetiapine
□ **Yes** □ **No**	**Does the patient have a diagnosis of mania or mixed episodes associated with Bipolar Disorder?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to three preferred alternatives, one of which is aripiprazole?** *(If yes, complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)*
□ **Yes** □ **No**	**Does the patient have a history of <u>intolerance or contraindication</u> to three preferred alternatives, one of which is aripiprazole?** *(If yes, complete Section D above, including the intolerance or contraindication)*

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QUANTITY LIMIT - CAPLYTA	
□ Yes □ No	**Is there rationale for needing to exceed the quantity limit of one capsule per day, at a maximum dose of 42 mg?** *If yes, provide rationale:*

Provider Signature: _____ **Date:** _____