UnitedHealthcare Community Plan

Antipsychotics - Arizona
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 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)* □ Schizophrenic spectrum disorder □ Bipolar Disorder □ Autism Spectrum Disorder □ Tourette's or other tic disorder
□ **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**	**Has the patient demonstrated failure or intolerance to a majority (not more than 3) of the preferred formulary/PDL alternatives for the given diagnosis?** *(If yes, complete Section D above)*
MEMBERS UNDER 6 YEARS OLD	
□ **Yes** □ **No**	**Is there documentation that psychosocial issues have been evaluated before the request for antipsychotic medications?**
□ **Yes** □ **No**	**Is there documentation of non-medication alternatives that have been attempted to address symptoms before the request for antipsychotic medications?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is there documentation including information on the expected outcomes and an evaluation of potential adverse events?**
□ **Yes** □ **No**	**Does the member have known hypersensitivity to the requested agent?**
□ **Yes** □ **No**	**Is the medication being prescribed by a Behavioral Health Provider?**
□ **Yes** □ **No**	**Does the prescriber attest they are aware of FDA labeling regarding the use of the antipsychotic medication and feels the treatment with the requested medication is necessary?** *If yes, list rationale:*
LONG-ACTING INJECTABLES	
□ **Yes** □ **No**	**Is the patient unable to take oral solid alternatives?** *If yes, list reason:*
□ **Yes** □ **No**	**If requesting Invega Trinza, has the patient been treated with Invega Sustenna for at least 4 months?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Has the patient established tolerability with any of the following?** *(If yes, check which applies and complete Section D above)* □ Aripiprazole □ Paliperidone □ Risperidone
□ **Yes** □ **No**	**Is the patient non-compliant with oral atypical antipsychotic dosage forms?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**If the patient is <18, does the prescriber attest they are aware of FDA labeling regarding use of long acting injectable antipsychotic products in patients less than 18 years of age and feels the treatment with the requested product is medically necessary?** *If yes, list rationale for use:*

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CONCOMITANT ANTIPSYCHOTIC TREATMENT	
□ **Yes** □ **No**	**Is the request for a cross taper?** *If yes, list start date of cross taper:*
□ **Yes** □ **No**	**Does the member have a known hypersensitivity to the requested medication(s)?**
□ **Yes** □ **No**	**Does the patient have one of the following indications?** *(If yes, check which applies)* □ Refractory schizophrenic spectrum disorder □ Refractory bipolar disorder with psychosis and/or severe symptoms
□ **Yes** □ **No**	**For refractory schizophrenic spectrum disorder: Is there evidence of adequate trials of at least three individual antipsychotics listed on the AHCCCS Behavioral Health Drug Lists, for 4-6 weeks at maximum tolerated doses?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**For refractory bipolar disorder with psychosis and/or severe symptoms: Is there evidence of at least four evidence based treatment options dependent upon the episode type, for trials of 4-6 weeks of maximum tolerated doses?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Is there supporting documentation that adherence to the treatment regimen has not been a contributing factor to the lack of response in the medication trials?**
ABILIFY MYCITE	
□ **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:*
□ **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
□ **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?**

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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: _____