

Prior Authorization Request Form for Aripiprazole (Abilify MyCite)



JOHNS HOPKINS
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**FAX Completed Form and
Applicable Progress Notes to:
(410) 424-4037**

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete the clinical assessment:

1. Does the patient have a documented attempt to use generic aripiprazole tablets, as verifiable in prescriber notes?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Was the patient non-compliant to the use of generic aripiprazole tablets, as verifiable in prescriber notes?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Do prescriber notes document the prescriber's attempt to counsel the patient on medication adherence?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have a documented trial of AT LEAST 12 weeks of Abilify Maintena?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Does the provider acknowledge that FDA labeling states that the ability of Abilify MyCite to improve patient compliance or modify aripiprazole dosage has not been established?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved

Step 3 I certify the above is true to the best of my knowledge.

Please sign and date:

Prescriber Signature

Date

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For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: