Prior Authorization Request Form for
Brexpiprazole (Rexulti)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

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

USFHP Pharmacy Prior Authorization Form

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

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: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the diagnosis major depressive disorder?	☐ Yes **Skip** to question 4	☐ No Proceed to question 3
3. Is the diagnosis schizophrenia?	☐ Yes **Skip** to question 7	☐ No **STOP** **Coverage not approved**
4. Has the patient had treatment failure with at least TWO other antidepressant augmentation therapies (one of which MUST be aripiprazole)?	☐ Yes **Skip** to question 6	☐ No Proceed to question 5
5. Has the patient experienced an adverse event with aripiprazole that is not expected to occur with brexpiprazole (Rexulti)?	☐ Yes Proceed to question 6	☐ No **STOP** **Coverage not approved**
6. Will the requested medication be used concurrently with an antidepressant?	☐ Yes **Sign and date on next page**	☐ No **STOP** **Coverage not approved**

Continue on next page

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7. Has the patient had treatment failure with at least TWO other atypical antipsychotics (one of which MUST be aripiprazole)?	☐ Yes **Sign and date below**	☐ No Proceed to question 8
8. Has the patient experienced an adverse event with aripiprazole that is not expected to occur with brexpiprazole (Rexulti)?	☐ Yes **Sign and date below**	☐ 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

[07 June 2017]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: