Prior Authorization Request Form for Abilify Maintena™

Please fax all Prior Authorization requests for medications to the Magellan Pharmacy Helpdesk at **866-498-0628**
Only one medication request per form • All fields must be complete and legible for review

Please allow one business day to process all non-urgent requests for medications. If the request is urgent, please call 800-790-1631.

All requests for reconsideration, regardless of reason, should be faxed to 866-498-0628 clearly marked "Reconsideration Request"

BHMP

BHMP NPI

BHMP NAME

BHMP SPECIALTY

CLINIC NAME

OFFICE PHONE

OFFICE FAX

CONTACT NAME

RECIPIENT

RECIPIENT ID NUMBER (CIS OR AHCCCS ID)

RECIPIENT NAME

RECIPIENT DATE OF BIRTH (MM/DD/YYYY)

FEMALE MALE

RECIPIENT SEX (CIRCLE)

Height (inches) Weight (lbs)

RECIPIENT HAS A DIAGNOSIS OF:

- ☐ Schizophrenia
- ☐ Bipolar Disorder Type 1
- ☐ Schizophreniform Disorder
- ☐ Other (document below)
- ☐ Schizoaffective Disorder

REQUEST

Abilify Maintena™		**IM**	**28 days**
MEDICATION NAME	STRENGTH AND FORM	ROUTE OF ADMINISTATION	FREQUENCY
DATE THERAPY INITIATED (MM/DD/YYYY)		EXPECTED LENGTH OF THERAPY	QUANTITY PER FREQUENCY

RATIONALE FOR EXCEPTION OR PRIOR AUTHORIZATION

Please indicate "YES" or "NO" to the following questions:

☐ YES	☐ NO	Does the recipient have a documented history of poor adherence to oral antipsychotics?
☐ YES	☐ NO	Can the recipient tolerate aripiprazole oral?
☐ YES	☐ NO	Is the recipient taking carbamazepine?
☐ YES	☐ NO	Have recipient education and other efforts to improve adherence to oral antipsychotics been tried (e.g. counseling with a Peer Medication Coach or Medi-Set training)?
☐ YES	☐ NO	The recipient is not currently on oral antipsychotics, or, if they are on oral, they will discontinue oral antipsychotics within 60 days after Abilify Maintena™ is initiated (within 14 days is recommended)?
☐ YES	☐ NO	Are target symptoms clearly documented and tracked over time in the psychiatric progress notes and assessments?
☐ YES	☐ NO	Are you also requesting approval for up to 60 days of oral aripiprazole? (14 days is recommended)

DOCUMENT OTHER RATIONALE FOR TREATMENT

BHMP'S SIGNATURE DATE

By signing this form, the practitionerr is attesting that documentation supporting the above information is recorded in the Patient's Medical Chart.

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