Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Abilify Maintena

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	State Lic ID:
City, State ZIP:	Address:	
Primary Phone:	City, State ZIP:	
Line of Business: □ Medicaid □ CHIP	Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient tried and failed Risperdal® Consta® and Invega® Sustenna?
☐ Yes ☐ No

Q2. Is the member over the age of 18?
☐ Yes ☐ No

Q3. Does the member have a diagnosis of schizophrenia?
☐ Yes ☐ No

Q4. Has the patient been started on Abilify MaintenaTM while inpatient? Please provide discharge summary with date of last injection.
☐ Yes ☐ No

Q5. Has the member tolerated treatment with oral Abilify® (aripiprazole) at a dose of 10 to 20 mg per day?
☐ Yes ☐ No

Q6. Does the patient have a history of long-term (greater than 3 months) non-compliance with oral antipsychotic medication which would prevent the patient from using oral formulary atypical antipsychotic medication? Please submit documentation.
☐ Yes ☐ No

Q7. Has the member failed measures (such as psychosocial interventions, psychoeducational interventions that have a behavorial component and supportive services, and providing member with instructions and problem-solving strategies such as reminders, self-monitoring tools, cues, and reinforcements) to improve compliance with formulary oral medications? Please submit documentation.
☐ Yes ☐ No

Q8. Does the member have significant clinical decompensation, or is the member at high risk for decompensation and

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Abilify Maintena

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**

functional impairment (ie. increased amount of hospitalizations, safety risk)? Please submit documentation.

☐ Yes ☐ No

Q9. Requested duration:

☐ 12 months ☐ Other:_____

Q10. Additional comments:

_____ _____

Prescriber Signature Date

Updated 2015