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Abilify MyCite Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk at 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
□ Abilify MyCite	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

Prior authorization (PA) is required for aripiprazole tablets with sensor (Abilify MyCite). Payment will be considered under the following conditions:

1. Patient has a diagnosis of schizophrenia, bipolar I disorder, or major depressive disorder; **and**
2. Patient meets the FDA approved age for use of the Abilify MyCite device; **and**
3. Dosing follows the FDA approved dose for the submitted diagnosis; **and**
4. Documentation of patient adherence to generic aripiprazole tablets is less than 80 percent within the past six months (prescriber must provide documentation of the previous six months worth of pharmacy claims for aripiprazole documenting non-adherence); **and**
5. Documentation of all the following strategies to improve patient adherence have been tried without success:
    a. Utilization of a pill box
    b. Utilization of a reminder device (e.g., alarm, application or text reminder)
    c. Involving family members or friends to assist
    d. Coordinating timing of dose with dosing of another daily medication; **and**

6. Documentation of a trial and intolerance to a preferred long-acting aripiprazole injectable agent; **and**
7. Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of four months use of Abilify MyCite. Initial approvals will be given for one month. Prescriber must review member adherence in the web-based portal and document adherence for additional consideration. If non-adherence continues, prescriber must document a plan to improve adherence. If adherence is improved, consideration to switch member to generic aripiprazole tablets must be considered. **Note**: the ability of the Abilify MyCite to improve patient compliance has not been established.
8. Requests will not be considered for patients in long-term care facilities.
9. A once per lifetime approval will be allowed.

The required trials may be overridden when documented evidence that the use of these agents would be medically contraindicated is provided.

Is patient adherence to generic aripiprazole tablets less than 80 percent within the past six months?
☐ Yes (provide previous six months of pharmacy claims documenting non-adherence) ☐ No

Have the following strategies to improve patient adherence been tried without success?
Utilization of pill box ☐ Yes ☐ No

Utilization of a reminder device (e.g., alarm, application, or text reminder)
☐ Yes; device used: _____ ☐ No

Involving family members or friends to assist ☐ Yes ☐ No

Coordinating timing of dose with dosing of another daily medication ☐ Yes ☐ No

Does patient reside in a long-term care facility? ☐ Yes ☐ No

Prescriber agrees to track and document adherence of Abilify MyCite through the web-based portal for health care providers and transition member to generic aripiprazole tablets after a maximum of 4 months use of Abilify MyCite?
☐ Yes ☐ No

Preferred long-acting aripiprazole injectable trial:
Drug name and dose: _____
Trial dates: _____ Failure reason: _____
_____
Medical or contraindication reason to override trial requirements: _____
_____
_____

Renewals:
Prescriber has reviewed member adherence of Abilify MyCite through the web based portal?
☐ Yes; adherence rate: _____ ☐ No

If improved member adherence, consider switch to generic aripiprazole tablets. Provider rationale for continued Abilify MyCite use if not switching to generic aripiprazole tablets: _____
_____
_____

If member continues to be non-adherent, document plan to improve adherence: _____
_____
_____

9. Physician signature

_____	_____
Prescriber or authorized signature	Date
Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.	
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