SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Abilify Mycite® (aripiprazole) **(Non-Preferred)**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Authorization Approval: Three (3) months

- ❑ Member must be ≥ 18 years of age

AND

- ❑ Have tolerability to oral aripiprazole with suboptimal effects (as assessed by prescriber) that may be due to adherence problems

AND

(Continued on next page)

- ❑ Have a smart phone compatible with the device

AND

- ❑ Give consent to a healthcare provider and caregiver (if applicable) to monitor the portal

AND

- ❑ There is a documented intervention by prescriber if nonadherence is detected.

Renewal Authorization Approval: Every Three (3) Months Reevaluate. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- **Member must:**
  - ❑ Continue to meet initial criteria

AND

  - ❑ Have prescriber attestation that member benefited from therapy

AND

  - ❑ Have prescriber attestation that there is a continued need for device (e.g., continued suboptimal effects and/or compliance)

AND

  - ❑ Have a healthcare provider and caregiver (if applicable) agree to continue to monitor device

AND

  - ❑ Not have worsened target symptoms

AND

  - ❑ Not have had any treatment-limited adverse effects (e.g., hypersensitivity, suicidality, neuroleptic malignant syndrome, tardive dyskinesia, metabolic changes, pathological gambling and other compulsive behaviors, orthostatic hypotension, falls, seizures, cognitive and motor impairment, dysphagia, disruption in body temperature regulation, and leukopenia, neutropenia, and agranulocytosis)

AND

  - ❑ Have a healthcare provider state reason why the patient cannot use long-acting injectable atypical antipsychotics if there is continued nonadherence.

_____

_____

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.