UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

ABILIFY MYCITE (aripiprazole tablets with sensor)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval: *(all the following must be met)*

- ❑ Patient is 18 years of age or older.
- ❑ Patient does not have dementia-related psychosis.
- ❑ Medication is for the treatment of (select applicable):
  - ❑ Schizophrenia
  - ❑ Bipolar I disorder
  - ❑ Adjunctive treatment of major depressive disorder.
- ❑ Patient has positive clinical response to aripiprazole **AND** demonstrated adherence challenges with taking medication.
- ❑ Trial and failure / inadequate response of at least one preferred long-acting injectable agent in the atypical antipsychotic drug class within the last six months:
  Medication(s) used: _____
  Duration of use: _____
  Details of Failure: _____
  Chart Note Page #: _____
- ❑ Plan to closely monitor patient adherence via the web-based portal for use by health care professionals.
- ❑ Patient is willing and capable to apply, wear, and appropriately change the wearable sensor patch, use a "smartphone", and use the drug-specific application.

Re-authorization Criteria:
Updated letter with medical justification or updated chart notes demonstrating positive clinical response and submitted "MyCite" report showing patient compliance greater than 80% with prescribed therapy.

Authorization: Up to three (3) months
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____
Prescriber's Signature Date