UnitedHealthcare Community Plan

Antipsychotics – Virginia
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Member Information			Prescriber Information		
Member Name:			Provider Name:		
Member ID:			NPI #:	Specialty:	
Date Of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP Code:	Office Street Address:		
Phone:	Allergies:		City:	State:	ZIP Code:

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____
Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Medication Information

Medication:	**Strength:**
Directions for use:	**Quantity:**

Medication Administered: ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

Clinical Information

What is the patient's diagnosis for the medication being requested? _____
_____

ICD-10 Code(s): _____

Are there any supporting laboratory or test results related to the patient's diagnosis*? (Please specify or provide documentation)*

Previous Medication Trials / Contraindications

Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

What medication(s) does the patient have a history of failure to? *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

What medication(s) does the patient have a contraindication or intolerance to? *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

Additional information that may be important for this review

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Patient First name:	Patient Last name:	Patient DOB:

Clinical and Drug Specific Information	
ALL REQUESTS	
□ Yes □ No	**Does the patient have any of the following diagnoses?** *(check which applies)* □ Autism □ Schizophrenia or schizoaffective disorder □ Bipolar disorder □ Tourette's □ Major depressive disorder
CHILDREN LESS THAN 18 YEARS OF AGE	
□ Yes □ No	**Is the prescriber a psychiatrist, neurologist, or developmental/behavioral pediatrician?**
□ Yes □ No	**If no to the above question, has the provider consulted a psychiatrist, neurologist, or developmental/behavioral pediatrician before prescribing the requested medication?**
□ Yes □ No	**Has the patient received a developmentally-appropriate, comprehensive psychiatric assessment with diagnoses, impairments, treatment target, and treatment plans clearly identified and documented?**
□ Yes □ No	**If no to the above question, is a psychiatric assessment scheduled, or are services not available in the area?** *(check which applies)* □ Psychiatric assessment is scheduled – start date: _____ □ Services are not available in the area □ Other reason:
□ Yes □ No	**Is psychosocial treatment in place without adequate clinical response, and psychosocial treatment with parental involvement will continue for the duration of therapy?**
□ Yes □ No	**Has informed consent for this medication been obtained from the parent or guardian?**
□ Yes □ No	**Has a family assessment been performed (including parental psychopathology and treatment needs), and have family functioning and parent-child relationship been evaluated?**
NON-PREFERRED MEDICATIONS	
□ Yes □ No	**Has the patient demonstrated failure or intolerance to TWO preferred formulary alternatives for the given diagnosis?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)* *If no, list reason:*
VRAYLAR	
□ Yes □ No	**Has the patient been receiving treatment with the requested non-preferred behavioral health medication and is new to the plan (enrollment effective date within the past 90 days)?**
□ Yes □ No	**Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?**
□ Yes □ No	**Does the patient have a diagnosis of schizophrenia or schizoaffective disorder?**
□ Yes □ No	**If yes to the above question, does the patient have a history of failure, contraindication, or intolerance to THREE preferred alternatives, one of which must be aripiprazole?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a diagnosis of depressive episodes associated with Bipolar I Disorder (bipolar depression)?**
□ Yes □ No	**If yes to the above question, does the patient have a history of failure, contraindication, or intolerance to both quetiapine AND fluoxetine used in combination with olanzapine?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*
□ Yes □ No	**Does the patient have a diagnosis of mania or mixed episodes associated with Bipolar Disorder?**
□ Yes □ No	**If yes to the above question, does the patient have a history of failure, contraindication, or intolerance to THREE preferred alternatives, one of which must be aripiprazole?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)*

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ABILIFY MYCITE	
□ Yes □ No	**Does the patient have tolerability to oral aripiprazole with suboptimal effects (as assessed by prescriber) that are due to adherence problems?**
□ Yes □ No	**Has there been a documented intervention by prescriber for nonadherence [e.g. utilization of a pill box, utilization of a smart phone reminder (ex: alarm, application, or text reminder), involving family members or friends to assist, coordinating timing of dose to coincide with dosing of another daily medication]?**
□ Yes □ No	**Does the patient have a smart phone compatible with the device?**
□ Yes □ No	**Has the patient given consent to a healthcare provider and caregiver (if applicable) to monitor the portal?**
CONTINUATION OF THERAPY - ABILIFY MYCITE	
□ Yes □ No	**Does the prescriber attest that the patient has benefited from therapy?**
□ Yes □ No	**Does the prescriber attest that there is a continued need for device (e.g., continued suboptimal effects and/or compliance)?**
□ Yes □ No	**Does the healthcare provider and caregiver (if applicable) agree to continue to monitor device?**
□ Yes □ No	**Has the patient had worsening of target symptoms?**
□ Yes □ No	**Has the patient 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)?**
□ Yes □ No	**Is there a reason why the patient cannot use long acting injectable atypical antipsychotic if there is continued nonadherence?** *If yes, document reason:*
QUANTITY LIMIT - CAPLYTA	
□ Yes □ No	**Is there rationale for needing to exceed the quantity limit of one capsule (42mg) per day?** *If yes, provide rationale:*

Provider Signature: _____ **Date:** _____