Department of HUMAN SERVICES

Request for Prior Authorization
Aripiprazole Tablets with Sensor (Abilify MyCite)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

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% within the past 6 months (prescriber must provide documentation of the previous 6 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 4 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 is provided that use of these agents would be medically contraindicated.

Non-Preferred

☐ Abilify MyCite

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

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Is patient adherence to generic aripiprazole tablets less than 80% within the past 6 months?

☐ Yes (provide previous 6 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:_____

_____

_____

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*