Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Atypical Antipsychotic Long-Acting Injectable (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Atypical Antipsychotic Long-Acting Injectable (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name ***(please circle)***

Abilify Maintena (aripiprazole) Aristada (aripiprazole lauroxil) Risperdal Consta (risperidone)

Invega Sustenna (paliperidone palmitate) Invega Trinza (paliperidone palmitate) Zyprexa Relprevv (olanzapine)

Other, please specify____

Quantity __________ Frequency _______________ Strength ___________

Route of Administration __________ Expected Length of therapy ______________

Patient Information

Patient Name: ________________________________

Patient ID: ________________________________

Patient Group No.: ________________________________

Patient DOB: ________________________________

Patient Phone: ________________________________

Prescribing Physician

Physician Name: ____

Specialty: __________________________ NPI Number: ________________________

Physician Fax: __________________________ Physician Phone: ________________________

Physician Address: __________________________ City, State, Zip: ________________________

Diagnosis:____________________________ **ICD Code:**____________________________

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Has the patient had a metabolic screening within the past 60 days? Y N

   [No further questions]

3. Has the patient been started on an antipsychotic, for an FDA approved indication and dose, during a recent hospitalization? Y N

[If yes, then no further questions.]

4. Is the patient stable on this treatment for an FDA approved indication and dose? Y N

   [If yes, then no further questions.]

5. Is the patient non-adherent to oral antipsychotics, placing the patient at risk for poor outcomes? Y N

   If no, please describe need for long-acting injection over oral formulations: ____

   [If no, then no further questions.]

6. Has the patient received the manufacturer's recommended oral dosage to confirm tolerability and efficacy prior to receiving the long-acting injection? Y N

   [If no, then no further questions.]

7. Will the patient continue taking oral antipsychotics BEYOND the manufacturer's recommended initial overlap period? Y N

   If yes, please describe rationale for concomitant use: ____

   [If yes, then no further questions.]

8. Does the patient have an FDA approved indication for the requested medication? Y N

   Note: All products are approved for schizophrenia. Invega Sustenna and Trinza are also approved for schizoaffective disorder. Risperdal Consta is also approved for Bipolar I.

   [If no, then no further questions.]

9. Will the provider support baseline and routine monitoring of all the following: A) weight, body mass index (BMI), or waist circumference, B) blood pressure, C) fasting glucose, D) fasting lipid panel, E) tardive dyskinesia (using the Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System Condensed User Scale (DISCUS))? Y N

   [If no, then no further questions.]

10. Is this request for Risperdal Consta or Invega Sustenna? Y N

    [If yes, then skip to question16.]

11. Is this request for Invega Trinza? Y N

[If no, then skip to question 13.]

12. Has the patient been stabilized on the same dose of Invega Sustenna for at least 4 months? Y N

[If yes, then skip to question 15.]

[If no, then no further questions.]

13. Has the patient had a trial and failure or intolerance to Risperdal Consta AND Invega Sustenna or Trinza? Y N

[If no, then no further questions.]

14. Is this request for Abilify Maintena? Y N

[If no, then skip to question 16.]

15. Is the patient taking a CYP3A4 inducer (i.e., carbamazepine, St. John's Wort, phenytoin, phenobarbital, rifampin, efavirenz)? Y N

[If yes, then no further questions.]

16. Is the medication being prescribed by, or in consultation with, a psychiatrist? Y N

[If no, then no further questions.]

17. Is the patient 18 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**