



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Abilify as Adjunctive Treatment of MDD

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

<p>Patient Name:</p> <p>Member Number:</p> <p>Date of Birth:</p> <p>Group Number:</p> <p>Address:</p> <p>City, State, Zip:</p> <p>Member Phone:</p>	<p>Prescriber Name:</p> <p>Fax: Phone:</p> <p>Office Contact:</p> <p>NPI: State Lic ID:</p> <p>Address:</p> <p>City, State, Zip:</p>
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Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

<p>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</p>
<p>Q1. What is the requested duration of therapy?</p> <p style="margin-left: 20px;">12 months or less</p> <p style="margin-left: 20px;">Greater than 12 months</p>
<p>Q2. Is the patient 18 years of age or older?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q3. Does the patient have a diagnosis of treatment resistant Major Depressive Disorder?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q4. Has the patient had an adequate trial and failure or an inadequate response, duration of at least 4 weeks or intolerance to monotherapy with 2 different antidepressant therapies at maximum dosing?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q5. Has the patient had a trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to a single trial of combination antidepressant therapy (such as a SSRI and bupropion or SNRI and bupropion)?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q6. Has the patient had a trial and failure of an inadequate response, duration of at least 4 weeks, or intolerance to a single trial of an antidepressant with augmentation therapy (such as lithium or valproate)?</p> <p style="margin-left: 20px;">Yes No</p>
<p>Q7. Comments:</p>

Physician Signature

Date