

Date/Time of Request: Date: _____ Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Abilify®** (aripiprazole). Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. – Member Information:

Patient Name:	Plan Name/Plan ID:		
Patient ID:	Patient Date of Birth:	Patient Contact Phone Number:	

B. – Physician Information

Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone Number:	Physician Fax Number:	
Drug Name and Strength:	Quantity and Days Supply:	NDC Number and GCN:	

C. – Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone Number:	Pharmacy Fax Number:
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D. – Clinical Information- Please fill out the following information: (circle all that apply)

Patient Diagnosis: _____ ICD9 Code: _____

- Has this patient had a trial and achieved an inadequate response to at least one of the following atypical antipsychotics (Risperdal, Seroquel or Zyprexa)? YES NO
- Has the therapy been recommended by a psychiatrist? YES NO
- Is this medication being used as adjunctive therapy to antidepressant therapy for the acute treatment of Major Depressive Disorder? YES NO

Dosing recommendations: 10-15mg PO QD (Schizophrenia); 30mg PO QD (Bipolar Mania); 2mg-15mg QD (Adjunctive treatment for patients on antidepressants)

Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To: ProCare PBM Clinical Division 3090 Premiere Parkway Ste 100, Duluth GA 30097
1-866-965-Drug (3784) / Fax # 866-999-7736

Receipt Date/Time of Completed Request: _____		FOR INTERNAL USE ONLY		Ticket Number: _____	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied	(Date/Time)	Member Contacted: _____		
Reviewed by: _____	Effective Date: _____	MD Contacted: _____			
Review Date: _____	Termination Date: _____	Pharmacy Contacted: _____			
Review Time: _____					