ProCare Rx

Abilify® aripiprazole

Ticket #: _____ Request Date: _____ Request Time: _____

# PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Abilify® ripiprazole. 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 #: |

| B. Physician Information | | |
|---|---|---|
| Physician Name: | Physician Address: | |
| Physician DEA #: | Physician Phone #: | Physician Fax #: |
| Drug Name and Strength: | QTY and Days Supply: | NDC # and GCN: |

| C. Pharmacy Information | | | |
|---|---|---|---|
| Pharmacy Name: | NABP #: | Pharmacy Phone #: | Pharmacy Fax #: |

| D. Clinical Information (Please fill out the following information: circle all that apply) | |
|---|---|
| Patient Diagnosis: | ☐ ICD-9 Code ☐ ICD-10 Code |

| | | |
|---|---|---|
| 1. | 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 |
| 2. | Has the therapy been recommended by a psychiatrist? | YES NO |
| 3. | 3a. Is this medication being used as adjunctive therapy to antidepressant therapy for the acute treatment of Major Depressive Disorder? (If yes, please answer question 3b.) | YES NO |
| | 3b. Has the patient tried and failed either Buspirone or Bupropion? | YES NO |
| 4. | 4a. Is this a re-authorization? (If yes, please answer question 4b.) | YES NO |
| | 4b. How long has this patient been taking Abilify? _____ | |

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, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.