



Please complete ALL information below and fax your request to 1-888-671-5285

Abilify Mycite® Coverage Determination Request Form

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Member Information (required)

Provider Information (required)

Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic) <input type="checkbox"/> Check if request is for continuation of therapy	Strength:	Dosage Form:
Directions for Use:		

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

- Prior Authorization**- Request is for a drug that requires prior authorization under the plan.
- Step Therapy**- Request is for an exception to try another drug before the requested drug being prescribed.
- Quantity Limit**- Request is for an exception to the plan's quantity limit.
Quantity per DAY requested? _____

Select the diagnosis below:

- Adjunctive treatment of major depressive disorder
- Bipolar I disorder
- Schizophrenia
- Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the prescriber attest that tracking ingestion of the medication is medically necessary? Yes No

Select the medication(s) the patient has a history of trial and failure, or intolerance to:

- | | |
|---|--|
| <input type="checkbox"/> Aripiprazole | <input type="checkbox"/> Quetiapine ER |
| <input type="checkbox"/> Olanzapine | <input type="checkbox"/> Risperidone |
| <input type="checkbox"/> Paliperidone extended-release (ER) | <input type="checkbox"/> Ziprasidone |
| <input type="checkbox"/> Quetiapine | |

Quantity limit requests:

Is there a high risk of significant adverse clinical outcome with medication change or dosage change? Yes No

Is the requested quantity and dose within FDA approved maximum dosing limits or supported by peer-reviewed medical literature, accepted standards of medical practice and/or medical compendia? Yes No

If yes, please specify: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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