Gateway Health

ABILIFY (aripiprazole) Adults 18 years of age and older
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services.

FAX: (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative.

PHONE:(800) 528-6738 Monday through Friday 8:30am to 4:30pm

PROVIDER INFORMATION

Requesting Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Patient Name:	
Gateway ID:	DOB:

DRUG INFORMATION

Medication:	**Strength:**
Frequency:	**Duration:**

MEDICAL HISTORY

Patient Age:

Diagnosis:

☐ Bipolar Disorder ☐ Schizophrenia ☐ Major Depressive Disorder ☐ Autism
☐ Unspecified Psychosis ☐ Other: _____

Recent Hospitalization:

Was Aripiprazole recently started while member was inpatient? ☐ Yes ☐ No

Previous Therapy

Drug Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why / Current)

Has the member had baseline monitoring of weight, BMI, blood pressure, fasting glucose and fasting lipid panel? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature	Date

Gateway Health

ABILIFY (aripiprazole) in Children Less than 18 Years Old
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services.
FAX: (412) 255-4544 or (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE:(800) 528-6738 Monday through Friday 8:30am to 4:30pm

PROVIDER INFORMATION

Requesting Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Patient Name:	
Gateway ID:	DOB:

DRUG INFORMATION

Medication:	**Strength:**
Frequency:	**Duration:**

MEDICAL HISTORY

Patient Age:

Diagnosis:

☐ Bipolar Disorder ☐ Schizophrenia ☐ Transient Encephalopathy
☐ Autism ☐ Mental Retardation ☐ Tourette's Syndrome
☐ Oppositional Defiant Disorder (ODD) with aggression
☐ Other: _____

Is this medication being prescribed by one of the following specialists or in conjunction with one of the following specialists?

☐ Pediatric Neurologist ☐ Child and Adolescent Psychiatrist ☐ Child Development Pediatrician
☐ Adult Psychiatrist ☐ PCP/Pediatrician

Previous Therapy

Drug Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why / Current)

Is there evidence of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above? (*Documentation of this must be provided via a fax attachment to this request*)

☐ Yes, please attach documentation to faxed form
☐ No

Has the member had baseline monitoring of weight, BMI, blood pressure, fasting glucose and fasting lipid panel? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

_____
_____

Prescribing Physician Signature	Date