

UPMC HEALTH PLAN

Abilify

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

THIS SECTION FOR PROVIDER USE ONLY—PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone:		Provider Fax:	
Patient Name:	Patient UPMC Health Plan ID Number:	Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:
<input type="checkbox"/> New medication <input type="checkbox"/> Ongoing medication	If ongoing, provide date started:	If medication is ongoing, Did the member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis:		Date of diagnosis:	

Medical History

Please indicate the diagnosis:

- Bipolar Disorder
 Schizophrenia
 Major Depression with Psychosis
 Major Depressive Disorder
 Other: _____

Please indicate if the member has been on the following: (Please complete all that apply)

Single Antidepressant Therapy - Please list below all medication tried and failed

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing

Combination Antidepressant Therapy- Please list below all medication tried and failed

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing

Antidepressant with Augmentation Therapy- Please list below all medication tried and failed

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing