Magellan HEALTHCARE℠

Abilify Maintena Injection Request Form
Fax to Magellan: 1.888.656.4916

(All requests must be approved in advance to insure authorization)

Today's Date: ____________________

Member Name: ____________________ Medicaid ID #: ____________________

Provider: ____________________ Contact: ____________________

Contact Phone Number: ____________________ Provider MIS #: ____________________

Service Location: ____

Current Diagnosis: ☐ Schizophrenia ☐ Other (please explain ____________________

____

Is the member over age 18? ☐ Yes ☐ No Is the member over age 65? ☐ Yes ☐ No
Dementia related psychosis? ☐ Yes ☐ No

What are the member's specific symptoms that are being targeted with this treatment? ____________

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The client's ability to tolerate extended exposure to Abilify has been established by the use of oral Abilify prior to receiving Abilify Maintena. Please list dates and doses that establishes this exposure, as well as response to oral Abilify: ____________________

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There is clear documentation that the client cannot take oral Risperdal (including M-tabs), oral Invega, oral Abilify or Risperdal Consta. Include member-specific reasons why Abilify Maintena is expected to be effective, even when these other medications were not: ____________________

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There is clear documentation that the client cannot be treated with Haldol Decanoate or Prolixin Decanoate:

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There is clear documentation that the client has been prescribed several oral antipsychotic medications, but could not be safely and effectively treated with any of those medications. ☐Yes ☐No (explain)

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The client has agreed to receive the injections on a regular basis, at the interval prescribed, and a person or agency that is geographically accessible and capable of dispensing the injections at the required frequency has been identified. ☐Yes ☐No

There is not more than one provider prescribing antipsychotic medications to this client. ☐Yes ☐No

Recent laboratory tests (CBC, lipid panel, FBS) have been completed and reviewed:
☐ Yes Date reviewed:____________________ ☐ No

Results: ____

____

> The maximum FDA approved dosage is 400mg each month. Amounts in excess of this dose and frequency have not been shown to have additional efficacy, so will not be authorized.

Please list all current medications and doses:

Medication:	Dosage:

Is the patient currently on medications that might induce cytochrome p450 (i.e. carbamazepine)?
☐Yes ☐No If yes, please list:

____

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> Initial Prior Authorization for Abilify Maintena will be for 4 months. Subsequent prior authorization frequency may be determined, and will be contingent upon evidence of clinical efficacy and appropriate clinical monitoring.

Dosage Information for Authorization:
Please authorize for: ______________ months or __________ injections.
Dosage given on each appointment date: ______________ (mg)
Dates of injections: ____________________ ____________________

____________________ ____________________

J0401 (Abilify Maintena) x ________ Units (1 mg = 1 unit)
96372 (injection) x ________ (number of injections)

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