HEALTH PLANS
UNIVERSITY OF UTAH

# PRIOR AUTHORIZATION REQUEST FORM
## BRAND ATYPICAL ANTIPSYCHOTICS

Abilify Maintena®, Fanapt®, Invega®, Invega Sustenna®, Invega Trinza®, Latuda®, Rexulti®, Risperdal Consta®, Saphris®, Vraylar®, Zyprexa Relprevv™

**For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.**

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

| | | |
|---|---|---|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |
| Height/Weight: | | |

***Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.***

**Product being requested**: ☐ Abilify Maintena® (aripiprazole injection), ☐ Fanapt® (iloperidone), ☐ Invega® (paliperidone extended, ☐ Invega Sustenna® (paliperidone injection), ☐ Invega Trinza® (paliperidone injection), ☐ Latuda® (lurasidone), ☐ Rexulti® (brexpiprazole), ☐ Risperdal Consta® (risperidone), ☐ Saphris® (asenapine), ☐ Vraylar® (cariprazine), ☐ Zyprexa Relprevv® (olanzapine)

Dosing/Frequency:_____

**If the request is for reauthorization, proceed to reauthorization section**

| Questions | Yes | No | Comments/Notes |
|---|---|---|---|
| 1. Is the medication requested being used according to its FDA approved indications? Please document the member's diagnosis. | ☐ | ☐ | **Please provide documentation** |
| 2. Has the member had a 3-month trial and failure of at least two formulary generic atypical antipsychotics? | ☐ | ☐ | **Please provide documentation** |
| **INJECTABLE ANTIPSYCHOTICS** | | | |
| 1. Is the requesting provider a psychiatrist or in consultation with one? | ☐ | ☐ | |
| 2. Does the member meet at least one of the following:<br>• Under court order for treatment with injectable antipsychotics<br>• Evidence of non-adherence to oral therapy resulting in hospitalization<br>• Unable to swallow oral dosage forms of antipsychotic medications | ☐ | ☐ | **Please provide documentation** |

| | | | |
|---|---|---|---|
| 3. For Invega Trinza®, has monthly Invega Sustenna® been established as adequate treatment for at least 4 months?<br>• Note: the last 2 doses of monthly paliperidone must be the same dosage strength before starting 3-month IM paliperidone. | ☐ | ☐ | **Please provide documentation** |
| **REAUTHORIZATION** | | | |
| 1. Is the request for reauthorization of therapy? | ☐ | ☐ | |
| 2. Has the patient responded to therapy as seen by disease improvement or stabilization? | ☐ | ☐ | **Please provide documentation** |

**What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.**

Additional information:

Physician Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM-010
Origination Date: 10/02/2018
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 11/01/2020