



## Catamaran Prior Authorization Department

Phone: 866-235-3062

Fax: 866-391-7222

### Prescriber Information

<b>Last Name:</b> <input type="text"/> <b>DEA/NPI:</b> <input type="text"/> <b>Phone</b> <input type="text"/>	<b>First Name</b> <input type="text"/> <b>Specialty:</b> <input type="text"/> <b>Fax</b> <input type="text"/>
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### Member Information

<b>Last Name:</b> <input type="text"/> <b>Member ID Number</b> <input type="text"/>	<b>First Name</b> <input type="text"/> <b>DOB:</b> <input type="text"/>
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### Medication Information:

<b>Drug Name and Strength:</b> <input type="text"/> <b>Diagnosis:</b> <input type="text"/>	<b>Quantity and Dosing:</b> <input type="text"/> <b>Duration:</b> <input type="text"/>
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## Abilify (aripiprazole) Discmelt Prior Authorization Criteria

**You must answer ALL of the following questions**

1. Please document ICD-9 code: _____		
2. Is the patient currently being treated with Abilify Discmelt?	Y	N
3. Is the patient unable to take tablets or capsules orally or at high risk for noncompliance?	Y	N
4. Is the patient taking other tablets or capsules indication that he or she can take non-dissolvable tablets?	Y	N
5. Does the patient have a diagnosis of major depressive disorder?	Y	N
6. Did the patient have an inadequate treatment response to or adverse drug event with a trial of at least three different antidepressants?	Y	N
7. Does the patient have a diagnosis of schizophrenia?	Y	N
8. Does the patient have a diagnosis of bipolar disorder (manic or mixed type)?	Y	N
9. Does the patient have a diagnosis of irritability associated with autistic disorder?	Y	N

## Abilify (aripiprazole) Tablets & Abilify Solution

**You must answer ALL of the following questions**

1. Please document ICD-9 code: _____		
2. Is the patient currently being treated with Abilify?	Y	N
3. Does the patient have a diagnosis of major depressive disorder?	Y	N
4. Did the patient have an inadequate treatment response to or adverse drug event with a trial of at least three different antidepressants?	Y	N
5. Does the patient have a diagnosis of schizophrenia?	Y	N
6. Does the patient have a diagnosis of bipolar disorder (manic or mixed type)?	Y	N

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7. Does the patient have a diagnosis of irritability associated with autistic disorder?

☐ Y☐ N

Comments: \_\_\_\_\_

*Information given on this form is accurate as of this date.*\_\_\_\_\_  
**Prescriber or Authorized Signature**\_\_\_\_\_  
**Date**\_\_\_\_\_  
**Authorized Medical Staff – Name/Title**

**Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department at 866-235-3062.**

**I understand that Catamaran's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).**