

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

**TODAY'S HEALTH**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Abilify® (aripiprazole): Quantity Limit Exception Form: Please respond.

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- Please complete the attached Abilify® (aripiprazole) Quantity Limit Exception Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Abilify® (aripiprazole)**

The current recommended maximum dose from the package labeling for aripiprazole is 30 mg/day. Current clinical trial data suggests that there is not a significant dose-related response. Expert consensus statements from the J Clin Psychiatry recommend that the highest acute treatment dose of aripiprazole should be limited to 30 mg/day, while the target dose in treatment resistant patients can reach 35 mg/day. Expert consensus also recommends that the maximum dose in patients > or =65 years of age should be limited to 15 mg/day. The current maximum daily dose under our quantity limit program is 30 mg/day. Doses in excess of 30 mg/day are not supported by the literature.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 01/23/2008

M0018\_PATEMP\_1107 CMS 11/28/07 H8742

# Quantity Limit Exception Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Abilify® (aripiprazole) Criteria

- 1 Please indicate product requested:  
 Abilify® tabs  Abilify Discmelt®  
 Abilify® solution  Abilify® injection
- 2 Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.  
 ICD-9: \_\_\_\_\_
- 3 Please specify indication for Abilify® use:  
 Schizophrenia or other chronic psychotic disorders  
 Bipolar Disorder  
 Behavioral disturbances in the elderly that impair functional ability  
 adjunctive treatment of major depression in patients receiving antidepressants  
 Other \_\_\_\_\_
- 4 If Abilify® injection is requested, please indicate the dispensing location:  
 the pharmacy  
 the physician, incident to a physician's visit  
 other: \_\_\_\_\_
- 5 Is the patient greater than or equal to 65 years old?  
 Yes  No
- 6 Is the patient currently taking Abilify?  
 Yes  No
- 7 If the answer to question #6 was yes, then answer the following:  
7 Is the patient compliant to the medication regimen (taken 95% of doses in last 30 days)?  
 Yes  No
- 8 How long has the current dose been used?  
 < 1 month  > 1 months
- 9 Please indicate which of the following best describes your patient's antipsychotic regimen  
 The patient receiving an enzyme inducer (e.g., carbamazepine).  
 The patient received a partial response and is tolerating the current dose.  
 The patient is receiving more than one atypical antipsychotic agent and is not in the process of dosage cross titration.
- A lipid panel, fasting glucose, weight, BMI, and BP should be evaluated prior to initiation & periodically thereafter.

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_