Aripiprazole (Abilify®) Criteria for Use

THIS SECTION FOR PROVIDER USE ONLY

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, laboratory 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 MR#:**	**Patient DOB:**

☐ **New Medication** ☐ **Ongoing Medication**	**If Ongoing, Provide Start Date:**	**If medication is ongoing, did the patient show improvement while on therapy?**	☐ **Yes** ☐ **No**

Medical History

Please indicate the diagnosis:

☐ **Bipolar Disorder** ☐ **Schizophrenia** ☐ **Major Depressive Disorder**
☐ **Other** _____

Schizophrenia or Bipolar Mania, Including Mixed/Manic (Please Complete this Section if Applicable)

Please indicate if your patient has been on the following: (please complete all that apply)

☐ **Tried and failed or was intolerant* to at least 2 Formulary Atypical Antipsychotic Agents – Please list below**

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing
1)	1)	1)	1)
2)	2)	2)	2)

Major Depressive Disorder (Please Complete this Section if Applicable)

Please indicate if your patient has been on the following: (please complete all that apply)

☐ **Failed or was intolerant to at least three other antidepressant therapies (list below)**

☐ **Single Antidepressant Therapy – Please list below all medications tried and failed**

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing

☐ **Combination Antidepressant Therapy – Please list below all medications tried and failed**

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing

☐ **Antidepressant with Augmentation Therapy – Please list below all medications tried and failed**

Drug Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuing

Is Aripiprazole being used in combination with an SSRI or SNRI? ☐ **Yes** ☐ **No**

If yes, please complete below:

Drug Name	Strength/Frequency	Dates of Therapy	Other Comments

Please provide any additional information which should be considered in the space below:

PLEASE ALLOW UP TO 72 HOURS TO OBTAIN A NON-FORMULARY (NF) DRUG

*** Intolerance is defined as any one of the following: increase in prolactin level, persistent hyperlipidemia (despite use of mitigating strategies), progression to overt diabetes mellitus, persistent weight gain (despite lifestyle modifications) leading to a body mass index > 25 kg/m^2, metabolic syndrome (patient should try ziprasidone before aripiprazole, provided that the patient does not have hypokalemia, hypomagnesemia, a history of arrhythmias, or other contraindications), neuroleptic malignant syndrome, or tardive dyskinesia.**

INSTRUCTIONS:

This form is the Fill In Form PDF version.

CHILD PSY, BAP, EPS, JAILS, MHUC:
E-mail scanned form to Dr. Meade, or fax to (408) 885-6126

OUTPATIENT ADULT PSYCHIATRISTS, COUNTY ADULT PSYCHIATRISTS, ALL CONTRACT AGENCIES:
E-mail scanned form to Dr. Ho, or fax to (408) 885-5788

ALL OTHERS:
Fax to (408) 282-2655

HOW TO LOCATE THIS FORM:

Go to http://valleypages/portal/site/HHS/
Along the left side select Pharmacy & Therapeutics
Select Forms and References
Under Forms find a PDF file named Abilify Criteria For Use_Fill In Form

Or go to www.sccmhd.org

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