



Physician's Prior Authorization Questionnaire
Abilify Discmelt®

Patient:

ID#:

DOB:

Patient Address:

Abilify Discmelt® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? (Please do not use codes.)

2. What other medications has the patient taken in the past for this condition?

3. Does the patient have any swallowing disorders? Yes No

If Yes, please describe:

Please supply medical records documenting the necessity for this dosage form. If medical records are not received, the request will be denied. Claims history will be searched for oral medications.

Physician's Signature

Date

Please Print Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx