US Family Health Plan
Prior Authorization Request Form for
Brexpiprazole **(Rexulti)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the diagnosis major depressive disorder?	☐ Yes **Skip** to question 4	☐ No Proceed to question 3
3. Is the diagnosis schizophrenia?	☐ Yes **Skip** to question 7	☐ No **STOP** **Coverage not approved**
4. Has the patient had treatment failure with at least TWO other antidepressant augmentation therapies (one of which MUST be aripiprazole)?	☐ Yes **Skip** to question 6	☐ No Proceed to question 5
5. Has the patient experienced an adverse event with aripiprazole that is not expected to occur with brexpiprazole (Rexulti)?	☐ Yes Proceed to question 6	☐ No **STOP** **Coverage not approved**
6. Will the requested medication be used concurrently with an antidepressant?	☐ Yes **Sign and date on next page**	☐ No **STOP** **Coverage not approved**

Continue on next page

Prior Authorization Request Form for Brexpiprazole (Rexulti)

7. Has the patient had treatment failure with at least TWO other atypical antipsychotics (one of which MUST be aripiprazole)?	☐ Yes **Sign and date below**	☐ No Proceed to question 8
8. Has the patient experienced an adverse event with aripiprazole that is not expected to occur with brexpiprazole (Rexulti)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

_____ _____
Prescriber Signature Date

[07 June 2017]