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 855-273-5735

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**
https://www.usfamilyhealth.org/for-providers/pharmacy-information/

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.	**Provider acknowledges that generic aripiprazole does not need a prior authorization and is available at a lower copay.**	☐ Acknowledged Proceed to question 2	
2.	**For which indication is the requested medication being prescribed?**	☐ Major Depressive Disorder – proceed to question 3 ☐ Schizophrenia – proceed to question 6 ☐ Alzheimer's Disease (AD) – proceed to question 9 ☐ Other – STOP Coverage not approved	
3.	**Is the patient greater than or equal to 18 years of age?**	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4.	**Will the requested medication be used concurrently with an antidepressant?**	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5.	**Has the patient had an inadequate response to treatment with at least TWO other antidepressant augmentation therapies (one of which MUST be aripiprazole)?**	☐ Yes **Sign and date on next page**	☐ No Proceed to question 8
6.	**Is the patient greater than or equal to 13 years of age?**	☐ Yes Proceed to question 7	☐ No **STOP** **Coverage not approved**
7.	**Has the patient had an inadequate response to treatment 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**

9. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 10	☐ No **STOP** **Coverage not approved**
10. Is the patient being treated for agitation associated with dementia due to Alzheimer's Disease (AD)?	☐ Yes Proceed to question 11	☐ No **STOP** **Coverage not approved**
11. Is the requested medication prescribed by a neurologist, psychiatrist or specialist in geriatric medicine?	☐ Yes Proceed to question 12	☐ No **STOP** **Coverage not approved**
12. Have other causes of agitation been ruled out or treated?	☐ Yes Proceed to question 13	☐ No **STOP** **Coverage not approved**
13. Has non-pharmacologic management of agitation failed?	☐ Yes Proceed to question 14	☐ No **STOP** **Coverage not approved**
14. Is the provider aware of the warnings, screening and monitoring precautions for the requested medication?	☐ 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 _____

[24 Jan 2024]