



Montana Healthcare Programs  
Drug Prior Authorization Coverage Criteria

Aristada™ (aripiprazole)

**Review Criteria**

Member must meet all the following criteria:

- Subject to Preferred Drug List requirements
- Member must be at least 18 years of age
- Member must have diagnosis of schizophrenia
- Member must have clinical rationale that oral therapy cannot be used
- Tolerability with corresponding oral molecule must be established prior requesting approval for injectable therapy
- Approval granted in one-year intervals