Montana Healthcare Programs Prior Authorization Request Form
for Use of Rexulti (brexpiprazole)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
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<tbody>
<tr>
<td>Member ID:</td>
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<tr>
<td>Prescriber Name/Specialty if applicable:</td>
<td>Prescriber Phone:</td>
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<td>Requested Dose:</td>
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Authorization will be granted only for the following diagnoses. Please complete applicable information:

☐ Major Depressive Disorder (as adjunctive treatment only):

1. Member has had an inadequate response, after at least 4 weeks of therapy, to at least two preferred antidepressant agents: ☐ Yes ☐ No

   Drug Name/Dates: ____________________________________________________________

   Drug Name/Dates: ____________________________________________________________

2. Member has had an inadequate response or contraindication to both:

   ☐ Aripiprazole as add-on therapy to an antidepressant: ☐ Yes ☐ No

   Date/Outcome: ______________________________________________________________

   ☐ Quetiapine as add-on therapy to an antidepressant: ☐ Yes ☐ No

   Date/Outcome: ______________________________________________________________

3. Member is concurrently taking an antidepressant: ☐ Yes ☐ No Drug name: ____________________________

☐ Schizophrenia:

Member has had an inadequate response, after at least 6 weeks of therapy, to at least two preferred, FDA-approved medications to treat schizophrenia: ☐ Yes ☐ No

Drug Name/Dates: ____________________________________________________________

Drug Name/Dates: ____________________________________________________________

LIMITATIONS: Major Depressive Disorder: 1 tablet daily, max 3mg daily; Schizophrenia: 1 tablet daily, max 4mg daily

Please complete form and fax to Drug Prior Authorization Unit at 1-800-294-1350.

1/2020