Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
P.O. Box 5119, Helena, MT 59604
Phone 406.443.6002 . Toll-Free 1.800.395.7961
Fax 406.513.1928 . Toll-Free 1.800.294.1350

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

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Requested Dose:		

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

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