			♥ aetna [™]				
AETNA BE	TTER HEALTH®						
Coverage Policy/Guideline							
Name: Aripiprazole Injecti		on	Page:	1 of 2			
Effective Date: 3/4/2024			Last Review Date:	01/2024			
Applies to:	⊠Illinois	□Florida	□Florida Kids				
	☐New Jersey	□Maryland	□Michigan				
	\square Pennsylvania Kids	□Virginia					

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for aripiprazole injection products under the patient's prescription drug benefit.

Description:

Abilify Asimtufii

Abilify Asimtufii is indicated is indicated for the treatment of schizophrenia in adults and maintenance monotherapy treatment of bipolar I disorder in adults.

Abilify Maintena

Abilify Maintena is indicated for the treatment of schizophrenia in adults and maintenance monotherapy treatment of bipolar I disorder in adults.

Aristada

Aristada is indicated for treatment of schizophrenia.

Aristada Initio

Aristada Initio, in combination with oral aripiprazole, is indicated for the initiation of Aristada when used for the treatment of schizophrenia in adults

Applicable Drug List:

Abilify Asimtufii Abilify Maintena Aristada Aristada Initio

Policy/Guideline:

The requested drug will be covered with prior authorization when the following criteria are met:

Tolerability with oral aripiprazole has been established

AND

- The requested drug is being prescribed for the treatment of schizophrenia
 OR
- Abilify Maintena or Abilify Asimtufii is being prescribed for maintenance monotherapy treatment of bipolar I disorder

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	□Pennsylvania Kids	□Virginia					

Approval Duration and Quantity Restrictions:

Approval: 12 months

Quantity Level Limit: Reference Formulary for drug specific quantity level limits

References:

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