

ANTIDEPRESSANTS, OTHER PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Antidepressants, Other, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antidepressants, Other** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name: _____
Name of office contact: _____		Specialty: _____	
Contact's phone number: _____		State license #: _____	
LTC facility contact/phone: _____		NPI: _____	MA Provider ID#: _____
RECIPIENT INFORMATION		Street address: _____	
Recipient Name: _____		Suite #: _____	City/state/zip: _____
Recipient ID#: _____	DOB: _____	Phone: _____	Fax: _____

CLINICAL INFORMATION

Non-preferred medication requested:			
<input type="checkbox"/> Aplenzin ER tablet	<input type="checkbox"/> Fetzima ER capsule	<input type="checkbox"/> Oleptro tablet	<input type="checkbox"/> venlafaxine ER tablet
<input type="checkbox"/> Brintellix tablet	<input type="checkbox"/> Forfivo XL 450 mg tablet	<input type="checkbox"/> Parnate tablet	<input type="checkbox"/> Viibryd tablet
<input type="checkbox"/> Cymbalta capsule	<input type="checkbox"/> Irenka 40 mg capsule	<input type="checkbox"/> phenelzine tablet	<input type="checkbox"/> Wellbutrin tablet
<input type="checkbox"/> desvenlafaxine ER tablet	<input type="checkbox"/> Khedezla ER tablet	<input type="checkbox"/> Pristiq tablet	<input type="checkbox"/> Wellbutrin SR tablet
<input type="checkbox"/> desvenlafaxine fumarate ER tablet	<input type="checkbox"/> Marplan tablet	<input type="checkbox"/> Remeron tablet	<input type="checkbox"/> Wellbutrin XL tablet
<input type="checkbox"/> duloxetine DR 40 mg capsule	<input type="checkbox"/> mirtazapine ODT	<input type="checkbox"/> Remeron ODT	<input type="checkbox"/> _____
<input type="checkbox"/> Effexor XR capsule	<input type="checkbox"/> Nardil tablet	<input type="checkbox"/> tranylcypromine tablet	
<input type="checkbox"/> Emsam patch	<input type="checkbox"/> nefazodone tablet	<input type="checkbox"/> venlafaxine IR tablet	
Strength: _____	Dose/directions: _____	Quantity: _____	Refills: _____
Diagnosis (<i>submit documentation</i>): _____		Dx code (<i>required</i>): _____	
1. Has the Recipient tried and failed any of the following preferred Antidepressants, Other? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimens tried and treatment outcomes</i>	
<input type="checkbox"/> bupropion IR, SR, or XL tablet	<input type="checkbox"/> mirtazapine tablet	<input type="checkbox"/> venlafaxine ER capsule	<input type="checkbox"/> No
<input type="checkbox"/> duloxetine 20 mg, 30 mg, or 60 mg capsule	<input type="checkbox"/> trazodone tablet		
2. Does the Recipient have any contraindications or intolerances to the preferred Antidepressants, Other listed in question (1)?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication names and associated intolerances and contraindications</i>	
		<input type="checkbox"/> No	
3. Has the Recipient tried and failed any of the SSRI Antidepressants (e.g., Celexa, Lexapro, Paxil, Prozac, Zoloft)?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of SSRIs tried and treatment outcomes</i>	
		<input type="checkbox"/> No	
4. Does the Recipient have any contraindications or intolerances to any of the SSRI Antidepressants?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication names and associated intolerances and contraindications</i>	
		<input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____	Date: _____
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