

ANTIDEPRESSANTS, SSRIs PRIOR AUTHORIZATION FORM

Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please include all requested documentation (chart notes, laboratory data, etc.). To review the prior authorization guidelines for Antidepressants, SSRIs, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Antidepressants, SSRIs** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

<u>PRIOR AUTHORIZATION REQUEST INFORMATION</u>		<u>PRESCRIBER INFORMATION</u>	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # 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#:
<u>RECIPIENT INFORMATION</u>		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:	<input type="checkbox"/> Brisdelle capsule	<input type="checkbox"/> Lexapro tablet*	<input type="checkbox"/> Paxil CR tablet*	<input type="checkbox"/> Sarafem tablet
	<input type="checkbox"/> Celexa tablet*	<input type="checkbox"/> Lexapro solution*	<input type="checkbox"/> Pexeva tablet	<input type="checkbox"/> sertraline solution
	<input type="checkbox"/> escitalopram solution	<input type="checkbox"/> paroxetine CR tablet	<input type="checkbox"/> Prozac Pulvule*	<input type="checkbox"/> Zoloft solution*
	<input type="checkbox"/> fluoxetine DR 90mg capsule	<input type="checkbox"/> Paxil suspension	<input type="checkbox"/> Prozac Weekly*	<input type="checkbox"/> Zoloft tablet*
	<input type="checkbox"/> fluvoxamine ER capsule	<input type="checkbox"/> Paxil tablet*		
Strength:	Directions:	Quantity:	Refills:	
Diagnosis:			Dx code (required):	
1. Has the Recipient tried and failed the preferred Antidepressants, SSRIs? <i>Check all that apply.</i> <input type="checkbox"/> citalopram tablet or solution <input type="checkbox"/> fluvoxamine tablet <input type="checkbox"/> escitalopram tablet <input type="checkbox"/> paroxetine tablet <input type="checkbox"/> fluoxetine capsule, tablet (10mg, 20mg, 60mg), or solution <input type="checkbox"/> sertraline tablet			<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and therapeutic failure</i> <input type="checkbox"/> No	
2. Does the Recipient have any contraindications or intolerances to the preferred agent listed in question (1)?			<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication name(s) and associated intolerances / contraindications</i> <input type="checkbox"/> No	
3. For non-preferred brand name products with available generics (marked with a * in the above non-preferred medication list), why can't the Recipient take the FDA-approved generic equivalent product? <i>Include reason in space below and submit medical record documentation supporting the brand medically necessary request.</i>				

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

Prescriber Signature:	Date:
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