FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Antidepressants Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Major depressive disorder (MDD)

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Continuation of therapy:

Has the patient been on continuous therapy with the requested medication for a minimum of 2 weeks? ❑ **Yes** ❑ **No**

Medication history:

Select the medications the patient has had an inability to tolerate or has had an inadequate response to:

❑ Bupropion
❑ Citalopram
❑ Desvenlafaxine
❑ Duloxetine
❑ Escitalopram
❑ Fluoxetine
❑ Fluvoxamine
❑ Paroxetine
❑ Sertraline
❑ Venlafaxine
❑ Other generic antidepressant(s) not listed above. (Please specify):_____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.