



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

Zoloft® Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Major depressive disorder (MDD)	
<input type="checkbox"/> Obsessive compulsive disorder (OCD)	
<input type="checkbox"/> Panic disorder	
<input type="checkbox"/> Posttraumatic stress disorder (PTSD)	
<input type="checkbox"/> Premenstrual dysphoric disorder (PMDD)	
<input type="checkbox"/> Social anxiety disorder (SAD)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Select the medications the patient has had an inability to tolerate or has had an inadequate response to:	
<input type="checkbox"/> Bupropion	<input type="checkbox"/> Fluoxetine
<input type="checkbox"/> Citalopram	<input type="checkbox"/> Fluvoxamine
<input type="checkbox"/> Desvenlafaxine	<input type="checkbox"/> Paroxetine
<input type="checkbox"/> Duloxetine	<input type="checkbox"/> Sertraline
<input type="checkbox"/> Escitalopram	<input type="checkbox"/> Venlafaxine
<input type="checkbox"/> 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.

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