FAX Completed Form To
1.833.404.2392
Pharmacy Help Desk
1.800.460.8988
Prescriber Help Desk
1.833.587.2012

Request for Prior Authorization
ANTIDEPRESSANTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for non-preferred antidepressants subject to clinical criteria. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered for patients when the following criteria are met: 1) The patient has a diagnosis of Major Depressive Disorder (MDD) and is 18 years of age or older; and 2) Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs; and 3) Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI; and 4) Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant . 5) If the request is for an isomer, prodrug or metabolite of a medication indicated for MDD, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. <u>Non-Preferred</u>

☐ Aplenzin ☐ Fetzima ☐ Khedezla ☐ Viibryd ☐ Other: _____

Strength_____**Dosage Instructions** _____ **Quantity**_____ **Days Supply**_____

Diagnosis:_____

Preferred Generic SSRI Trial 1: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

Preferred Generic SSRI Trial 2: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

Preferred Generic SNRI Trial: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

Preferred Non-SSRI/SNRI Generic Antidepressant Trial: Drug Name& Dose_____
Trial Dates:_____ Failure Reason_____

Medical or contraindication reason to override trial requirements: _____

_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*