Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

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. Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; 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; and 5) Documentation of a previous trial and therapy failure at a therapeutic dose with vilazodone; and 6) Documentation of a previous trial and therapy failure at a therapeutic dose with vortioxetine; and 7) Documentation of a previous trial and therapy failure at a therapeutic dose with an antidepressant plus adjunct; and 8) If the request is for dextromethorphan and bupropion extended- release tablet (Auvelity), one of the trials must include a previous trial and inadequate response at a therapeutic dose with an extended-release bupropion agent; and 9) If the request is for an isomer, prodrug or metabolite of the requested medication, 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.

Non-Preferred

☐ Aplenzin ☐ Auvelity ☐ Fetzima ☐ 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_____

Vilazodone Trial: Dose_____ Trial Dates:_____

Failure Reason_____

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Vortioxetine Trial: Dose_____ Trial Dates:_____

Failure Reason_____

Antidepressant plus adjunct trials:

Antidepressant Trial: Drug Name & Dose_____ Trial Dates:_____

Failure Reason_____

Adjunct Trial: Drug Name & Dose_____ Trial Dates:_____

Failure Reason_____

Requests for Auvelity:

Extended-Release Bupropion Trial: 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 Health and Human Services, that the member continues to be eligible for Medicaid.*