

OPTIMA HEALTH MEDICAID

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed.**

ANTIDEPRESSANTS

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight: _____ Date: _____

Drug Requested: (Check Below the drug that applies)

SSRIs PREFERRED MEDICATIONS (Does not require Prior Authorization)

- | | | |
|---|---|--|
| <input type="checkbox"/> Citalopram soln/tab | <input type="checkbox"/> escitalopram tablets | <input type="checkbox"/> fluoxetine cap/soln |
| <input type="checkbox"/> fluvoxamine cap/soln | <input type="checkbox"/> paroxetine tablets | <input type="checkbox"/> sertraline con/soln/tab |

SSRIs NON-PREFERRED

All Non-Preferred Medications Require Prior Authorization (Member must have tried and failed at least two (2) of the Preferred **SSRI drugs).**

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Brisdelle® | <input type="checkbox"/> Celexa® tablets | <input type="checkbox"/> escitalopram soln | <input type="checkbox"/> fluoxetine DR cap/tab |
| <input type="checkbox"/> fluvoxamine ER | <input type="checkbox"/> Lexapro® tablets | <input type="checkbox"/> Luvox® CR | <input type="checkbox"/> Paroxetine CR |

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<input type="checkbox"/> Paxil® tab/susp	<input type="checkbox"/> Paxil® CR	<input type="checkbox"/> Pexeva®	<input type="checkbox"/> Prozac® cap/weekly
<input type="checkbox"/> Sarafem®	<input type="checkbox"/> Zoloft® conc/tab		
OTHER ANTIDEPRESSANTS PREFERRED MEDICATIONS (Does not require Prior Authorization)			
<input type="checkbox"/> Bupropion IR, SR, XL	<input type="checkbox"/> Desvenlafaxine ER tab (generic for Pristiq®)	<input type="checkbox"/> Mirtazapine ODT/tab	
<input type="checkbox"/> Trazodone tab	<input type="checkbox"/> Venlafaxine IR tab & ER cap	<input type="checkbox"/> Viibryd® tablets	
OTHER ANTIDEPRESSANTS <u>NON-PREFERRED</u> All Non-Preferred Medications Require Prior Authorization (Member must have tried and failed at least two (2) of the OTHER ANTIDEPRESSANT Preferred drugs).			
<input type="checkbox"/> Aplenzin®	<input type="checkbox"/> Auvelity™	<input type="checkbox"/> Brintellix®	<input type="checkbox"/> bupropion XL (generic Forfivo® XL)
<input type="checkbox"/> desvenlafaxine ER tab (generic for Khedezla™)	<input type="checkbox"/> Effexor® XR	<input type="checkbox"/> Emsam® transdermal	<input type="checkbox"/> Fetzima®
<input type="checkbox"/> Forfivo® XL	<input type="checkbox"/> Khedezla™	<input type="checkbox"/> Marplan®	<input type="checkbox"/> Nardil®
<input type="checkbox"/> nefazodone	<input type="checkbox"/> Oleptro® ER	<input type="checkbox"/> Parnate®	<input type="checkbox"/> phenelzine
<input type="checkbox"/> Pristiq®	<input type="checkbox"/> Remeron® ODT/tab	<input type="checkbox"/> tranylcypromine sulfate	<input type="checkbox"/> Trintellix
<input type="checkbox"/> venlafaxine ER tab	<input type="checkbox"/> Viibryd® dose pk	<input type="checkbox"/> Wellbutrin® IR, SR & XL	

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Provide clinical evidence that the **Preferred** drug(s) will not provide adequate benefit and list pharmaceutical drugs attempted and outcome.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****