SENTARA HEALTH PLANS

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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Antidepressant Drugs

Drug Requested: Select one drug below

❑ **Fetzima®** (levomilnacipran)	❑ **Trintellix®** (vortioxetine)	❑ **vilazodone** (Viibryd®)

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

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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.

- ❑ Member must meet **ALL** the following:
  - ❑ Member has had at least a 30-day trial and failure of a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., venlafaxine, desvenlafaxine, duloxetine) **(verified by chart notes or pharmacy paid claims)**
  - ❑ Member has had at least a 30-day trial and failure of a selective serotonin reuptake inhibitor (SSRI) (e.g., citalopram, sertraline, fluoxetine) **(verified by chart notes or pharmacy paid claims)**
  - ❑ Member has had at least a 30-day trial and failure of one other antidepressant agent (e.g., bupropion, mirtazapine, TCA) **(verified by chart notes or pharmacy paid claims)**

(Continued on next page)

Check each drug that has been tried. If not checked, authorization process will be delayed.		
❑ bupropion	❑ citalopram	❑ desvenlafaxine
❑ duloxetine	❑ escitalopram	❑ fluoxetine
❑ mirtazapine	❑ paroxetine	❑ sertraline
❑ venlafaxine ER	❑ Other: _____	

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required

****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.****

***Approved by Pharmacy and Therapeutics Committee: 9/26/2024**
REVISED/UPDATED/REFORMATTED: ~~2/20/2014; 3/21/2014; 5/7/2014; 10/30/2014; 5/21/2015~~; ~~12/27/2015~~; ~~5/3/2016;~~ ~~5/27/2016~~; ~~12/16/2016; 8/13/2017; 6/11/2019; 8/12/2019;10/16/2023;~~ **10/15/2024**