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

ANTIDEPRESSANTS

Drug Requested: (Check below the drug that applies)

SSRIs PREFERRED MEDICATIONS (Does not require Prior Authorization)		
❑ citalopram soln/tab	❑ escitalopram tablets	❑ fluoxetine cap/soln
❑ fluvoxamine tablets	❑ paroxetine tablets	❑ 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)**			
❑ Brisdelle®	❑ Celexa® tablets	❑ citalopram HBR 30mg	❑ escitalopram soln
❑ fluoxetine DR cap/tab	❑ fluvoxamine ER	❑ Lexapro® tablets	❑ paroxetine CR
❑ paroxetine susp	❑ Paxil® tab/susp	❑ Paxil® CR	❑ Prozac® cap/weekly
❑ sertraline cap	❑ Zoloft® conc/tab		

OTHER ANTIDEPRESSANTS PREFERRED MEDICATIONS (Does not require Prior Authorization)		
❑ bupropion IR, SR, XL	❑ desvenlafaxine ER tab (generic for Pristiq®)	❑ mirtazapine ODT/tab
❑ trazodone tab	❑ venlafaxine IR tab & ER cap	❑ vilazodone tab

OTHER ANTIDEPRESSANTS NON-PREFERRED **All Non-Preferred Medications Require Prior Authorization (Member must have tried and failed at least two (2) of the OTHER ANTIDEPRESSANT Preferred drugs).**			
❑ *Auvelity™ *see criteria if requesting for AAD	❑ Bupropion XL (generic Forfivo® XL)	❑ desvenlafaxine ER tab (generic for Khedezla™)	❑ Effexor® XR
❑ Emsam® transdermal	❑ Exxua™	❑ Fetzima®	❑ Khedezla™
❑ Marplan®	❑ Nardil®	❑ nefazodone	❑ phenelzine
❑ Pristiq®	❑ Raldesy™	❑ Remeron® ODT/tab	❑ tranylcypromine
❑ Trintellix	❑ venlafaxine ER tab	❑ Viibryd® dose pk	❑ Viibryd® tab
❑ Wellbutrin® SR			

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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.

- ❑ For Non-Preferred drugs, member has tried and failed at **least two (2) Preferred** drugs **from the corresponding class** ❑ **Yes** ❑ **No**

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

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❑ **For Auvelity requests prescribed for Agitation Associated with dementia due to Alzheimer's Disease (AAD)**
Recommended Dosage: Initial: one tablet of 30mg/105mg daily for 7 days, increase dose on day 8 to twice daily. After 14 days may increase to dextromethorphan 45 mg/bupropion 105 mg twice daily. Maximum daily dose: dextromethorphan 90 mg/bupropion 210 mg
Quantity Limit: 2 tablets per day

- ❑ Member is 18 years or older
- ❑ Member has a diagnosis of Alzheimer's disease
- ❑ Member has a diagnosis of agitation and exhibits moderate to severe symptoms

*****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.****