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 cap/soln	❑ 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	❑ escitalopram soln	❑ fluoxetine DR cap/tab
❑ fluvoxamine ER	❑ Lexapro® tablets	❑ Luvox® CR	❑ Paroxetine CR
❑ Paxil® tab/susp	❑ Paxil® CR	❑ Pexeva®	❑ Prozac® cap/weekly
❑ Sarafem®	❑ 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).**			
❑ Aplenzin®	❑ Auvelity™	❑ Brintellix®	❑ bupropion XL (generic Forfivo® XL)
❑ desvenlafaxine ER tab (generic for Khedezla™)	❑ Effexor® XR	❑ Emsam® transdermal	❑ Fetzima®
❑ Forfivo® XL	❑ Khedezla™	❑ Marplan®	❑ Nardil®
❑ nefazodone	❑ Oleptro® ER	❑ Parnate®	❑ phenelzine
❑ Pristiq®	❑ Remeron® ODT/tab	❑ tranylcypromine sulfate	❑ Trintellix
❑ venlafaxine ER tab	❑ Viibryd® dose pk	❑ Viibryd® tab	❑ Wellbutrin® IR, SR & XL

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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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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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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.*