



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE-Fexmid®

M.D. Last Name: _____ *M.D. First Name:* _____

Physician Phone: _____ *Physician Fax:* _____

Patient _____ *ID#* _____ *DOB* _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL****

- 1. Does the patient have a hypersensitivity to any component of this product? Yes No
- 2. Is the patient currently being treated with, or has he/she used a MAOI in the past 14 days?
Ex. Isocarboxazid (Marplan), tranylcypromine (Parnate), phenelzine (Nardil), selegiline (Eldepryl, Emsam) Yes No
- 3. Has the patient had a recent myocardial infarction? Yes No
- 4. Does the patient have any cardiac arrhythmias? Yes No
- 5. Does the patient have either heart block or conduction disturbances? Yes No
- 6. Does the patient have congestive heart failure? Yes No
- 7. Does the patient have hyperthyroidism? Yes No
- 8. Has the patient tried and failed generic cyclobenzaprine? Yes No
 - a. If Yes, provide dates of trial _____
 - b. If No, provide the rationale for non-trial _____
- 9. Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
11900 W. Lake Park Dr.
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:
877-526-9906

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