



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE-PRISTIQ®

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. Diagnosis:

- Major Depressive Disorder (MDD)
- Other (please specify): _____

2. Does the patient have a hypersensitivity to desvenlafaxine, venlafaxine, or to any excipients in the desvenlafaxine formulation?

Yes No

3. Is the patient currently being treated with, or have they used a MAOI in the past 14 days?
(Ex. Emsam, Marplan, Nardil, Parnate (tranylcypromine))

Yes No

4. Is the patient currently stable on the medication?

Yes No

a. If Yes, provide the date therapy was initiated _____

b. If No, proceed to Question #5

5. Has the patient tried and failed Effexor XR?

Yes No

a. If Yes, provide dates of trial _____

b. If No, provide the rationale for non-trial _____

6. Does the patient have renal function impairment? If Yes, please specify below.

Yes No

- Mild renal function impairment (CrCl 50-80 mL/min)
- Moderate renal function impairment (CrCl 30-50 mL/min)
- Severe renal function impairment (CrCl <30 mL/min) or end-stage renal disease

6. Dose Requested: 50mg 100mg

7. Frequency Requested: Daily Every Other Day Multiple Daily Dose

8. Physician Signature or name of person providing answers _____

Physician Comments _____

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

RESTAT
P.O. BOX 758
WEST BEND, WI 53095
www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906