Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE - Branded SSRI/Combo's & SNRI

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

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#***_____ ***DOB*** _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please indicate which agent is being requested:

STEP B*

☐ Lexapro ☐ Effexor XR

☐ Cymbalta[1]

STEP C**

☐ Other Brand SSRI, SSRI combination, SNRI

_____

***Please note that if member is beginning therapy with an SSRI/SNRI, the member's benefit will only cover a generic SSRI, unless the member has already tried and failed a SSRI in the past.**

****Please Note that Step C drugs will not be approved unless all Step B drugs have been tried and failed**

[1]**Cymbalta is approvable as Step A for diabetic neuropathy (attach chart notes for documentation/proof of use for this indication).**

2. For Step B Coverage ONLY: Has the patient tried and failed a 30-day trial of an SSRI? Yes No

3. Please explain the reason for failure or non-trial, and attach notes from the patient's chart as documentation.

_____

_____

4. Is the patient currently taking a Monoamine Oxidase Inhibitor? Yes No
5. Does the patient have existing hypertension? Yes No
6. Is the patient breastfeeding? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

_____

_____

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

RESTAT
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WEST BEND, WI 53095

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QUESTIONS PLEASE CALL:
877-526-9906