



Antidepressants Prior Authorization of Benefits (PAB) Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information		2. Physician information	
Name: _____		Prescribing physician: _____	
Patient ID #: _____		Address: _____	
DOB: _____		Phone: _____	
Date _____ of _____	Rx: _____	Fax: _____	
Phone: _____		Physician specialty: _____	
Email: _____		Physician DEA: _____	
		Physician NPI #: _____	
		Email: _____	
3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
			Specify: _____
7. Diagnosis:			
8. Approval criteria: (Check all boxes that apply.)			
Note: Any areas not filled out are considered not applicable and may affect the outcome of this request.			
Prior authorization is required for nonpreferred antidepressants subject to clinical criteria. Requests for doses above the manufacturer recommended dose will not be considered. Payment will be considered when the following criteria are met:			
<ol style="list-style-type: none"> The patient has a diagnosis of major depressive disorder (MDD) and is 18 years of age or older. Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant. If the request is for an isomer, prodrug or metabolite of a medication indicated for MDD, one of the trials must be with the preferred parent drug of the same chemical entity that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated. 			
Nonpreferred: <input type="checkbox"/> Aplenzin <input type="checkbox"/> Fetzima <input type="checkbox"/> Khedezla <input type="checkbox"/> Viibryd <input type="checkbox"/> Other			
Preferred generic SSRI trial 1:	Drug name and dose _____		
Trial dates: _____			
Failure reason _____			
Preferred generic SSRI trial 2:	Drug name and dose _____		
Trial dates: _____			
Failure reason _____			

Preferred	generic	SNRI	trial:	Drug	name	and	dose__
Trial dates: _____							
Failure reason _____							
Preferred non-SSRI/SNRI	generic	antidepressant	trial:	Drug	name	and	dose__
Trial dates: _____							
Failure reason _____							
Medical or contraindication reason to override trial requirements: _____							
<i>Attach lab results and other documentation as necessary.</i>							
9. Physician signature							
_____				_____			
Prescriber or authorized signature				Date			
<p><i>Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.</i></p>							
<p>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</p>							
<p>The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.</p>							