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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:

1. The patient has a diagnosis of major depressive disorder (MDD) and is 18 years of age or older.
2. Documentation of a previous trial and therapy failure at a therapeutic dose with two preferred generic SSRIs.
3. Documentation of a previous trial and therapy failure at a therapeutic dose with one preferred generic SNRI.
4. Documentation of a previous trial and therapy failure at a therapeutic dose with one non-SSRI/SNRI generic antidepressant.
5. 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: ☐ Aplenzin ☐ Fetzima ☐ Khedezla ☐ Viibryd ☐ 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: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

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.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.