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A Dohmen Company

Date _____

PRIOR AUTHORIZATION QUESTIONNAIRE-Cymbalta®

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:

- ☐ Chronic musculoskeletal pain
- ☐ Diabetic peripheral neuropathic pain
- ☐ Fibromyalgia
- ☐ Generalized anxiety disorder
- ☐ Major depressive disorder
- ☐ Other (please specify): _____

2. Is the patient currently taking a Monoamine Oxidase Inhibitor? Yes No
   Ex. Emsam, Marplan, Nardil, Parnate (tranylcyromine)

For diagnosis of chronic musculoskeletal pain, diabetic peripheral neuropathic pain, and fibromyalgia skip to Question #6

3. 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 #4

4. Is the patient currently stable on Lexapro or Effexor XR? 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 a 30-day supply of an SSRI? Yes No

   a. If Yes, specify drug and dates of trial _____

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

6. Physician Signature or name of person providing answers _____

Physician Comments _____

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

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Milwaukee, WI 53224

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906

 Date 11/08/2010