

Date \_\_\_\_\_

**PRIOR AUTHORIZATION QUESTIONNAIRE-Cymbalta®**

<b>M.D. Last Name:</b> _____	<b>M.D. First Name:</b> _____
<b>Physician Phone:</b> _____	<b>Physician Fax:</b> _____
<b>Patient</b> _____	<b>ID#</b> _____ <b>DOB</b> _____

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

1. Diagnosis:

- |   |   |
|---|---|
| <input type="checkbox"/> Chronic musculoskeletal pain | <input type="checkbox"/> Diabetic peripheral neuropathic pain |
| <input type="checkbox"/> Fibromyalgia                 | <input type="checkbox"/> Generalized anxiety disorder         |
| <input type="checkbox"/> Major depressive disorder    | <input type="checkbox"/> Other (please specify): _____        |

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

**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**

Restat  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:  
**877-526-9906**

[www.restat.com](http://www.restat.com)

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