EXPRESS SCRIPTS®

Prior Authorization Form
Antidepressant SSRI Step Therapy

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**

If this an **URGENT** request, please call 1-800-417-8164

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Celexa 10mg
- ☐ Celexa 20mg
- ☐ Celexa 40mg
- ☐ Celexa 10mg/5ml Solution
- ☐ Lexapro 5mg
- ☐ Lexapro 10mg
- ☐ Lexapro 20mg
- ☐ Lexapro 5mg/5ml Solution
- ☐ Luvox CR 100mg
- ☐ Luvox CR 150mg
- ☐ Paxil 10mg
- ☐ Paxil 20mg
- ☐ Paxil 30mg
- ☐ Paxil 40mg
- ☐ Paxil 10mg/5mg Solution
- ☐ Paxil CR 12.5mg
- ☐ Paxil CR 25mg
- ☐ Paxil CR 37.5mg
- ☐ Pexeva 10mg
- ☐ Pexeva 20mg
- ☐ Pexeva 30mg
- ☐ Pexeva 40mg
- ☐ Prozac 10mg
- ☐ Prozac 20mg
- ☐ Prozac 40mg
- ☐ Prozac 20mg/5ml Solution
- ☐ Prozac Weekly 90mg
- ☐ Sarafem 10mg Tablet
- ☐ Sarafem 10mg Capsule
- ☐ Sarafem 15mg Tablet
- ☐ Sarafem 20mg Tablet
- ☐ Sarafem 20mg Capsule
- ☐ Viibryd 10mg
- ☐ Viibryd 20mg
- ☐ Viibryd 40mg
- ☐ Viibryd Starter Kit
- ☐ Zoloft 25mg
- ☐ Zoloft 50mg
- ☐ Zoloft 100mg
- ☐ Zoloft 20mg/ml Solution
- ☐ Other: _____

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:		
1. Is the patient currently taking the requested medication? If yes, how long has the patient been taking the medication? _____	☐ Yes	☐ No
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: ☐ Requested medication covered under previous insurance plan ☐ Started medication in hospital ☐ Other: _____	☐ Yes	☐ No
3. Was the patient on this medication on a previous occasion?	☐ Yes	☐ No
4. Is the patient suicidal?	☐ Yes	☐ No

5. Does the patient have any potential drug interactions with fluoxetine (Prozac), fluvoxamine (Luvox), sertraline (Zoloft), or paroxetine (Paxil)? If yes, please list medications: _____ _____	☐ Yes	☐ No

6. Please indicate which generic SSRI's the patient has tried:

- ☐ Citalopram (generic)
- ☐ Escitalopram (generic)
- ☐ Fluoxetine delayed-release 90mg capsule (generic)
- ☐ Fluoxetine (generic)
- ☐ Fluvoxamine (generic)
- ☐ Paroxetine controlled-release (generic)
- ☐ Paroxetine (generic)
- ☐ Sertraline (generic)
- ☐ Other: _____

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.