Prior Authorization Request Form for Antidepressant, SSRIs

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	**II. MEMBER INFORMATION**
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)

Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: ____________________

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Antibiotics, GI and Related Agents? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.	Yes ☐ No	Medications Taken Previously (start and end date and dose):____________

- ☐ Member has a current history (within past 90 days) of using the prescribed the requested non-preferred SSRI antidepressant, since:____________
- ☐ If requesting for daily quantity exceeding daily limit (https://www.pahealthwellness.com/providers/pharmacy.html under PHW Quantity Limit List), please provide supporting information:____________

Therapeutic Duplication:

If concurrently prescribed a therapeutic duplicate (i.e. antidepressant different from the agent being requested):

- ☐ Member is titrated to or tapered from one SSRI antidepressant to another with the intent of discontinuing one of the medications
- ☐ Member has a medical reason for concomitant use of the requested medications supported by peer-reviewed literature or national treatment guidelines. Supporting evidence:____________

Yes

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)