

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient’s needs:
Please refer to the patient’s PDL for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient transitioning from one antidepressant to another or will the patient remain on both medications? <i>(If yes, check which applies)</i></p> <p><input type="checkbox"/> Patient will remain on both medications <i>List medications that are being used together:</i></p> <p><input type="checkbox"/> Transitioning from one antipsychotic to another <i>List medication that will be stopped and date it will be stopped:</i></p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Will the patient remain on five or more psychotropic/mental health medications or is the patient titrating/changing medications and will be on less than five psychotropic/mental health medications? <i>(Check which applies)</i></p> <p><input type="checkbox"/> Patient will remain on five or more psychotropic medications</p> <p><input type="checkbox"/> Transitioning medications AND will be on LESS THAN five psychotropic medications <i>List drugs that will be stopped and date they will be stopped:</i></p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently on the requested drug? <i>If yes, list start date:</i>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?</p> <p><i>If yes, list start date and discharge date:</i></p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of failure, contraindication or intolerance to any alternatives from at least two of the following classes: <i>(If yes, check which applies and complete Section D above)</i></p> <p><input type="checkbox"/> Alpha-2 Receptor Antagonists (Tetracyclics)</p> <p><input type="checkbox"/> Norepinephrine-Dopamine Reuptake Inhibitors <input type="checkbox"/> Selective Serotonin Reuptake Inhibitor (SSRI)</p> <p><input type="checkbox"/> Selective Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) <input type="checkbox"/> Serotonin Modulators</p>
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Do both of the following apply to the patient:</p> <p><input type="checkbox"/> Trial of two preferred products, other than the generic equivalent to the requested brand</p> <p><input type="checkbox"/> Trial of the generic equivalent of the product being requested from 5 manufacturers. <i>(If fewer than 5 manufacturers, must try all manufacturers)</i></p> <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width:33%;"><u>Medications</u></th> <th style="width:33%;"><u>Trail Dates</u></th> <th style="width:33%;"><u>Generic Manufacturer</u></th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	<u>Medications</u>	<u>Trail Dates</u>	<u>Generic Manufacturer</u>															
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SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient using the requested medication with a Selective Serotonin Reuptake Inhibitor (SSRI), Serotonin Norepinephrine Reuptake Inhibitor (SNRI), or Serotonin Modulator–Miscellaneous (SMM)? <i>(If yes, complete Section D above)</i></p>
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TETRACYCLIC ANTIDEPRESSANTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient using the requested medication with an Alpha-2 Receptor Antagonists–Tetracyclics (TeCA), Norepinephrine–Dopamine Reuptake Inhibitor (NDRI), Serotonin Norepinephrine Reuptake Inhibitor (SNRI), or Serotonin Modulator–Miscellaneous (SMM)? <i>(If yes, complete Section D above)</i></p>
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NDRI (BUPROPION)

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Is the patient using the requested medication with another Norepinephrine-Dopamine Reuptake Inhibitor (NDRI) or an Alpha-2 Receptor Antagonists-Tetracyclics (TeCA)? <i>(If yes, complete Section D above)</i></p>
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Member First name:	Member Last name:	Member DOB:
SEROTONIN MODULATOR–MISCELLANEOUS (SMM)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient using the requested medication with a Selective Serotonin Reuptake Inhibitor (SSRI), Alpha-2 Receptor Antagonists-Tetracyclics (TeCA), Serotonin Norepinephrine Reuptake Inhibitor (SNRI), or Serotonin Modulator-Miscellaneous (SMM)? <i>(If yes, complete Section D above)</i>	
SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITOR (SNRI)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient using the requested medication with a Selective Serotonin Reuptake Inhibitor (SSRI), Alpha-2 Receptor Antagonists-Tetracyclics (TeCA), Serotonin Norepinephrine Reuptake Inhibitor (SNRI), or Serotonin Modulator-Miscellaneous (SMM)? <i>(If yes, complete Section D above)</i>	
CONTINUATION OF THERAPY		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there documentation of positive clinical response to treatment? <i>If yes, list response:</i>	

Provider Signature: _____ **Date:** _____

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