



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: _____
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Please indicate which drug and strength is being requested:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Celexa 10mg | <input type="checkbox"/> Paxil 10mg | <input type="checkbox"/> Pexeva 30mg | <input type="checkbox"/> Sarafem 20mg Tablet |
| <input type="checkbox"/> Celexa 20mg | <input type="checkbox"/> Paxil 20mg | <input type="checkbox"/> Pexeva 40mg | <input type="checkbox"/> Sarafem 20mg Capsule |
| <input type="checkbox"/> Celexa 40mg | <input type="checkbox"/> Paxil 30mg | <input type="checkbox"/> Prozac 10mg | <input type="checkbox"/> Viibryd 10mg |
| <input type="checkbox"/> Celexa 10mg/5ml Solution | <input type="checkbox"/> Paxil 40mg | <input type="checkbox"/> Prozac 20mg | <input type="checkbox"/> Viibryd 20mg |
| <input type="checkbox"/> Lexapro 5mg | <input type="checkbox"/> Paxil 10mg/5mg Solution | <input type="checkbox"/> Prozac 40mg | <input type="checkbox"/> Viibryd 40mg |
| <input type="checkbox"/> Lexapro 10mg | <input type="checkbox"/> Paxil CR 12.5mg | <input type="checkbox"/> Prozac 20mg/5ml Solution | <input type="checkbox"/> Viibryd Starter Kit |
| <input type="checkbox"/> Lexapro 20mg | <input type="checkbox"/> Paxil CR 25mg | <input type="checkbox"/> Prozac Weekly 90mg | <input type="checkbox"/> Zoloft 25mg |
| <input type="checkbox"/> Lexapro 5mg/5ml Solution | <input type="checkbox"/> Paxil CR 37.5mg | <input type="checkbox"/> Sarafem 10mg Tablet | <input type="checkbox"/> Zoloft 50mg |
| <input type="checkbox"/> Luvox CR 100mg | <input type="checkbox"/> Pexeva 10mg | <input type="checkbox"/> Sarafem 10mg Capsule | <input type="checkbox"/> Zoloft 100mg |
| <input type="checkbox"/> Luvox CR 150mg | <input type="checkbox"/> Pexeva 20mg | <input type="checkbox"/> Sarafem 15mg Tablet | <input type="checkbox"/> Zoloft 20mg/ml Solution |
| | | | <input type="checkbox"/> 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? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: <input type="checkbox"/> Requested medication covered under previous insurance plan <input type="checkbox"/> Started medication in hospital <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Was the patient on this medication on a previous occasion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Is the patient suicidal?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No								
6. Please indicate which generic SSRI's the patient has tried: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"><input type="checkbox"/> Citalopram (generic)</td> <td style="width: 50%; border: none;"><input type="checkbox"/> Paroxetine controlled-release (generic)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Fluoxetine delayed-release 90mg capsule (generic)</td> <td style="border: none;"><input type="checkbox"/> Paroxetine (generic)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Fluoxetine (generic)</td> <td style="border: none;"><input type="checkbox"/> Sertraline (generic)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Fluvoxamine (generic)</td> <td style="border: none;"><input type="checkbox"/> Other: _____</td> </tr> </table>			<input type="checkbox"/> Citalopram (generic)	<input type="checkbox"/> Paroxetine controlled-release (generic)	<input type="checkbox"/> Fluoxetine delayed-release 90mg capsule (generic)	<input type="checkbox"/> Paroxetine (generic)	<input type="checkbox"/> Fluoxetine (generic)	<input type="checkbox"/> Sertraline (generic)	<input type="checkbox"/> Fluvoxamine (generic)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Citalopram (generic)	<input type="checkbox"/> Paroxetine controlled-release (generic)									
<input type="checkbox"/> Fluoxetine delayed-release 90mg capsule (generic)	<input type="checkbox"/> Paroxetine (generic)									
<input type="checkbox"/> Fluoxetine (generic)	<input type="checkbox"/> Sertraline (generic)									
<input type="checkbox"/> Fluvoxamine (generic)	<input type="checkbox"/> 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.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.