

Desvenlafaxine, Fetzima[®], Trintellix[®], Viibryd[®] Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
What is the patient's diagnosis for the medication being requested? _____ ICD-10 Code(s): _____					
Clinical information: Select if the patient has a trial and failure of at least 30 days with the following: <input type="checkbox"/> Citalopram <input type="checkbox"/> Escitalopram <input type="checkbox"/> Fluoxetine <input type="checkbox"/> Paroxetine <input type="checkbox"/> Sertraline <input type="checkbox"/> Venlafaxine extended-release <i>Documentation must be provided</i> Was the patient initiated on therapy with the requested medication while covered under another insurance plan and converted to Sentara/Optima coverage within the last <u>60 days</u> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Subject to verification by Sentara/Optima</i>					
Quantity limit requests: What is the quantity requested per DAY? _____ Previous therapies failed and/or therapies currently used in combination with the requested medication (<i>List ALL medications tried or authorization process will be delayed</i>): _____ _____ _____ Is the prescribed dose higher than the maximum dose recommendation in FDA-approved labeling (i.e., the package insert)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes , please provide documentation to support the safety and efficacy of the higher dose (such as evidence from practice guidelines or clinical trials from peer-reviewed medical literature). ** Please note: Chart documentation of the above is required to be submitted along with this fax _____ _____					
Use of samples to initiate therapy does not meet step edit/ preauthorization criteria. *Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*					
Prescriber Signature: _____			Date: _____		

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**



Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



Desvenlafaxine, Fetzima[®], Trintellix[®], Viibryd[®] Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Desvenlafaxine-Fetzima-Trintellix-Viibryd_Optima_2018Jan-W