mercy care

Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/completecare-forproviders/pharmacy

Antidepressants Non-Preferred
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information			
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female	Height:
Member ID:	City:	State:	Weight:

Prescribing Provider Information			
Provider Name (first & last):	Specialty:	NPI#	DEA#
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone		Office Fax:

Dispensing Pharmacy Information		
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information			
Selective Serotonin Reuptake Inhibitors (SSRIs):	☐ Pexeva	☐ Fluoxetine WEEKLY	☐ Fluoxetine TABLETS
	☐ Fluvoxamine ER	☐ Paroxetine ER	☐ Paroxetine mesylate capsule

Serotonin/Norepinephrine Reuptake Inhibitors (SNRIs):	☐ Fetzima	☐ Venlafaxine SR TABS	☐ Pristiq	☐ Khedezla	☐ desvenlafaxine

Selective Serotonin Reuptake Inhibitors (SSRI) / Serotonin 5-HT1A Receptor Partial Agonist:	☐ Viibryd
Selective Serotonin Reuptake Inhibitors (SSRI) / Serotonin 5-HT1A Receptor Agonist / Serotonin 5-HT3 Receptor Antagonist:	☐ Trintellix

Others:	☐ Aplenzin	☐ Forfivo XL	☐ Nefazodone

☐ Other, please specify:

Are there any contraindications to formulary medications? (If yes, please specify):	☐ Yes	☐ No	☐ New request	☐ Continuation of Therapy

If continuation request, has the member responded to therapy with this medication?	☐ Yes	☐ No

Is member new to Plan and/or was using samples of a non-preferred antidepressant AND currently stable? (circle one): ☐ Yes ☐ No	Was the non-preferred antidepressant started during a recent hospitalization? (circle one): ☐ Yes ☐ No

Medication request is NOT for FDA-approved, or compendia-supported diagnosis (circle one): ☐ Yes ☐ No	ICD-10 Diagnosis Code:	Diagnosis:
Directions for Use:	Strength:	Dosage Form:
	Quantity:	Day Supply:
		Duration of Therapy/Use:

Turn-Around Time for Review	
☐ Standard – (24 hours)	☐ **Urgent** – waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature:_____

☐ **Clinical Criteria for All New Starts**			
Is there a formulary preferred agent available in different formulation that is of the same ingredient? (for example, Pexeva, Aplenzin, Forfivo XL, fluvoxamine ER, paroxetine mesylate, fluoxetine weekly)		☐ Yes	☐ No
Was there documented trial and failure with that formulary agent?	☐ Yes	☐ No	☐ N/A

Additional Criteria			
☐ **Major Depressive Disorder**	☐ **Seasonal Affective Disorder**		
Is there documented trial and failure, intolerance, OR contraindication to 1 formulary agent from at least 4 different classes of antidepressants for at least 4 weeks? (SSRI, SNRI, bupropion, and mirtazapine)?	☐ Yes	☐ No	☐ N/A
Is there documented trial AND failure, intolerance, OR contraindication with 2 formulary agents PLUS an antidepressant augmentation regimen for at least 4 weeks? (SSRI or SNRI PLUS one of the following: Bupropion, Lithium, atypical antipsychotic, Buspirone OR Liothyronine)	☐ Yes	☐ No	☐ N/A
Are ONE of these trials with a preferred formulary agent from the same class (SSRI or SNRI)?	☐ Yes	☐ No	
☐ **Obsessive-Compulsive Disorder**			
Is there documented trial AND failure, intolerance, OR contraindication to 3 formulary agents (2 SSRIs and clomipramine) for at least 4 weeks?	☐ Yes	☐ No	
☐ **Panic Disorder**	☐ **Generalized Anxiety Disorder**		
Is there documented trial AND failure OR intolerance to 3 formulary agents from at least 2 different classes of antidepressants for at least 4 weeks? (SSRIs or SNRIs)	☐ Yes	☐ No	
☐ **Hot Flashes Associated with Menopause**			
Is there documented trial AND failure OR intolerance to 3 formulary agents from at least 2 different classes of antidepressants for at least 4 weeks? (SSRIs or SNRIs)	☐ Yes	☐ No	
Is member preference to avoid hormonal therapy?	☐ Yes	☐ No	
☐ **Premenstrual Dysphoric Disorder**			
Is there documented trial AND failure OR intolerance to 3 formulary SSRIs for at least 4 weeks?	☐ Yes	☐ No	

Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records.

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 800-624-3879 to check the status of a request.