

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 DOCUMENTATION (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 Antidepressant, SSRIs? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.		☐ Yes <i>Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.</i> ☐ No	
☐ 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 (Refer to https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/Quantity-Limits-and-Daily-Dose-Limits.aspx), 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			
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.)