Prior Authorization Request Form for
Desvenlafaxine succinate ER (Pristiq) and **desvenlafaxine ER (Khedezla, Desvenlafaxine ER)**

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: ______________________ Physician Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Sponsor ID # ______________________ Phone #: ______________________

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. Is use of venlafaxine immediate-release or extended-release contraindicated in this patient?	☐ Yes Proceed to question 2	☐ No **SKIP** to question **3**
2. Is use of any other formulary antidepressant not clinically appropriate?	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Has the patient previously responded to Khedezla, Pristiq or Desvenlafaxine ER and changing to a formulary medication would incur unacceptable risk *(for example, the patient is currently stabilized on Khedezla, Pristiq or Desvenlafaxine ER and changing to a formulary medication would present a risk of destabilization)***?**	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Does the patient require therapy with an SNRI [*serotonin-norepinephrine reuptake inhibitor*] *(for example, due to failure of SSRI therapy)***?**	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Has the patient tried and been unable to tolerate venlafaxine?	☐ Yes Sign and date below	☐ No Proceed to question 6
6. Is the patient being treated for depression?	☐ Yes Proceed to question 7	☐ No **STOP** Coverage not approved
7. Has the patient failed an adequate trial of venlafaxine? *(An adequate trial is generally considered to be 4 to 8 weeks in duration because of the amount of time required to achieve maximal benefit with an SNRI medication.)*	☐ Yes Sign and date below	☐ No Coverage not approved

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Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

______________________________ ____________

Prescriber Signature Date

[06 August 2014]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: