Prior Authorization Request Form for

escitalopram oxalate 15 mg capsules

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100
Hanover, MD 21076

Fax completed form and applicable progress notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

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

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

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

Prior authorization does not expire until implementation of complete exclusion status.

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

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

2 **Please complete the clinical assessment:**

1. **Provider acknowledges that escitalopram oxalate 15 mg capsules will be completely excluded from the TRICARE pharmacy benefit 120 days after the signing of the P&T Committee meeting minutes by the Director, DHA.**	☐ **Acknowledged** Proceed to question **2**
2. **Provider acknowledges that other escitalopram formulations are available to TRICARE beneficiaries and do not require prior authorization.**	☐ **Acknowledged** Proceed to question **3**
3. **What is the indication or diagnosis?**	☐ Major depressive disorder – Proceed to question **4** ☐ Generalized anxiety disorder – Proceed to question **5** ☐ Other diagnosis – **STOP – Coverage not approved**
4. **How old is the patient?**	☐ 12 years of age or older and younger than 65 years of age - Proceed to question **6** ☐ 65 years of age or older - **STOP – Coverage not approved**
5. **How old is the patient?**	☐ Younger than 65 years of age - Proceed to question **6** ☐ 65 years of age or older - **STOP – Coverage not approved**

6. Please document why the patient cannot take formulary alternatives.	_____ **Sign and date below**

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

3

_____ _____
Prescriber Signature Date

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