TRICARE Prior Authorization Request Form for
levomilnacipran XR **(Fetzima)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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.

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:**

1. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. Does the provider acknowledge that the patient and provider have discussed that non-pharmacologic interventions (for example, cognitive- behavioral therapy (CBT), sleep hygiene) are encouraged to be used in conjunction with this medication?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Is the requested drug being used for the treatment of depression?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**

4. Does the patient have a contraindication to, intolerability to, or has failed a trial of THREE formulary antidepressant medications for example: • **SSRIs** (selective serotonin reuptake inhibitors, for example, citalopram, escitalopram, fluoxetine, paroxetine, sertraline), • **SNRIs** (serotonin/norepinephrine reuptake inhibitors, for example, venlafaxine, duloxetine; not including milnacipran), • **tricyclic antidepressants** (TCAs, for example, amitriptyline, desipramine, imipramine, nortriptyline), • **mirtazapine,** • **bupropion,** • **trazodone immediate-release,** • **nefazodone, and** • **monoamine oxidase inhibitors** (MAOIs)**?** • **Note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose.**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

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

_____ _____
Prescriber Signature Date

[28 December 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: