

Prior Authorization Request Form for
levomilnacipran (**Fetzima**) and vortioxetine (**Trintellix**)



JOHNS HOPKINS
M E D I C I N E

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HEALTHCARE

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:			
	1. What drug is being requested?	<input type="checkbox"/> Trintellix – proceed to question 2 <input type="checkbox"/> Fetzima – proceed to question 2		
	2. Is the requested drug being used for the treatment of depression?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved	
	3. Please note for the following questions: The formulary antidepressants are: 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).		Proceed to question 4	
	4. Has the patient failed an adequate trial of a formulary antidepressant? <i>(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 therapy.)</i>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 5	
	5. Has the patient been unable to tolerate a formulary antidepressant?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 6	
	6. Has the patient previously responded to the requested medication or is currently stabilized on it?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No SKIP to question 8	
	7. Would changing to a formulary medication present a risk of destabilization?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Proceed to question 8	
	8. Is use of a formulary antidepressant contraindicated (for example, hypersensitivity to a dye or other inert ingredient)?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No STOP Coverage not approved	
9. Is the use of any other formulary antidepressant not clinically appropriate?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No Coverage not approved		

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

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Prescriber Signature

Date

[15 April 2015]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: