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

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. What drug is being requested?	☐ Trintellix – proceed to question 2 ☐ Fetzima – proceed to question 2	
2. Is the requested drug being used for the treatment of depression?	☐ Yes Proceed to question 3	☐ 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? *(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.)*	☐ Yes Sign and date below	☐ No Proceed to question 5
5. Has the patient been unable to tolerate a formulary antidepressant?	☐ Yes Sign and date below	☐ No Proceed to question 6
6. Has the patient previously responded to the requested medication or is currently stabilized on it?	☐ Yes Proceed to question 7	☐ No **SKIP** to question **8**
7. Would changing to a formulary medication present a risk of destabilization?	☐ Yes Sign and date below	☐ No Proceed to question 8
8. Is use of a formulary antidepressant contraindicated (for example, hypersensitivity to a dye or other inert ingredient)?	☐ Yes Proceed to question 9	☐ No **STOP** Coverage not approved
9. Is the use of any other formulary antidepressant not clinically appropriate?	☐ Yes Sign and date below	☐ No Coverage not approved

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

Prescriber Signature		Date	

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