AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Antidepressant Drugs

Drug Requested: Select one drug below

❑ **Fetzima®** (levomilnacipran)	❑ **Trintellix®** (vortioxetine)	❑ **vilazodone** (Viibryd®)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: ______________________________

Member Sentara #: ______________________________ **Date of Birth:** ______________

Prescriber Name: ______________________________

Prescriber Signature: ______________________________ **Date:** ______________

Office Contact Name: ______________________________

Phone Number: ______________________________ **Fax Number:** ______________

NPI #: ______________________________

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: ______________________________

Dosing Schedule: ______________________________ **Length of Therapy**: ______________

Diagnosis: ______________________________ **ICD Code, if applicable:** ______________

Weight (if applicable): ______________________________ **Date weight obtained:** ______________

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must meet **ALL** the following:
  - ❑ Member has had at least a 30-day trial and failure of a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., venlafaxine, desvenlafaxine, duloxetine) **(verified by chart notes or pharmacy paid claims)**
  - ❑ Member has had at least a 30-day trial and failure of a selective serotonin reuptake inhibitor (SSRI) (e.g., citalopram, sertraline, fluoxetine) **(verified by chart notes or pharmacy paid claims)**
  - ❑ Member has had at least a 30-day trial and failure of one other antidepressant agent (e.g., bupropion, mirtazapine, TCA) **(verified by chart notes or pharmacy paid claims)**

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Check each drug that has been tried. If not checked, authorization process will be delayed.		
❑ bupropion	❑ citalopram	❑ desvenlafaxine
❑ duloxetine	❑ escitalopram	❑ fluoxetine
❑ mirtazapine	❑ paroxetine	❑ sertraline
❑ venlafaxine ER	❑ Other: ________________________	

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee: 9/26/2024**
REVISED/UPDATED/REFORMATTED: ~~2/20/2014; 3/21/2014; 5/7/2014; 10/30/2014; 5/21/2015; 12/27/2015; 5/3/2016; 5/27/2016; 12/16/2016; 8/13/2017; 6/11/2019; 8/12/2019;10/16/2023;~~ **10/15/2024**