HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
BRAND ANTIDEPRESSANTS
Emsam®, Fetzima®, Trintellix®, Viibryd®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Emsam® (selegiline transdermal system), ☐ Fetzima® (levomilnacipran), ☐ Trintellix® (vortioxetine), ☐ Viibryd® (vilazodone)

Dosing/Frequency:____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a diagnosis of major depressive disorder?	☐	☐	**Please provide documentation**
3. Has the member tried and failed at least one generic selective serotonin reuptake inhibitor (SSRI) (e.g., sertraline, citalopram, fluoxetine, etc.)?	☐	☐	**Please provide documentation**
4. Has the member tried and failed at least one generic serotonin norepinephrine reuptake inhibitor (SNRI) (e.g., venlafaxine, duloxetine, etc.)?	☐	☐	**Please provide documentation**
5. Has the member tried and failed at least one of the following: • mirtazapine • bupropion • any other antidepressant	☐	☐	**Please provide documentation**
Emsam ONLY:			
1. Does clinical documentation show that the member is unable to swallow or has severe dysphagia preventing member from taking solid oral medications?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had a clinically significant response to therapy?	☐	☐	**Please provide documentation**

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3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 005
Origination Date: 01/15/2018
Reviewed/Revised Date: 03/25/2020
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