

Brand SSRIs and SNRIs

(Cymbalta, Lexapro, Luvox CR, Pexeva, Pristiq, Viibryd)

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet		Date: ____/____/____	
To: <u>Wellmark Pharmacy Services</u>		From (Prescriber's Name): _____	
Fax Number: <u>(866) 884-4345</u>		Prescriber's DEA Number: _____	
Phone Number: <u>(800) 600-8065</u>		Prescriber's Phone Number: _____	
Prescriber's Specialty: _____		Prescriber's Fax Number: _____	
Prescriber's Office Address: _____			
Street	Suite #	City	State Zip
Patient Name: _____			
Patient ID: _____		Patient DOB: ____/____/____	

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Does the patient have a diagnosis of Fibromyalgia, Diabetic Peripheral Neuropathy, or Chronic Pain? _____
 - a. If yes; please indicate prior therapies tried and failed: _____
 - b. If no; please provide the diagnosis this therapy has been prescribed for: _____
 ICD-9 Code: _____

2. Has the patient currently been taking the requested medication for at least 2 months? Yes No
 If yes, was the patient using samples of the medication? Yes No

3. Select all Selective Serotonin Reuptake Inhibitors (SSRIs) and/or Selective Serotonin and Norepinephrine Reuptake Inhibitors (SSNRIs or SNRIs) that the patient has tried and failed (from the table below):

Select	Drug Name	Date(s) Tried/Failed	Reason for Discontinuation
<input type="checkbox"/>	Generic Celexa (citalopram)		
<input type="checkbox"/>	Generic Effexor/XR (venlafaxine/ER cap)		
<input type="checkbox"/>	Generic Luvox (fluvoxamine)		
<input type="checkbox"/>	Generic Paxil/CR (paroxetine)		
<input type="checkbox"/>	Generic Prozac/Weekly (fluoxetine)		
<input type="checkbox"/>	Generic Venlafaxine ER (venlafaxine ER tab)		
<input type="checkbox"/>	Generic Wellbutrin/SR/XL (bupropion)		
<input type="checkbox"/>	Generic Zoloft (sertraline)		

4. Drug Name Requested: _____ Drug Strength: _____ mg

Quantity per Day: _____ units

Directions: _____

Printed Name _____ Signature _____

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