

# Oleptro (trazodone extended-release)

## Prior Authorization Request (Physician to Complete)



Visit [www.wellmark.com](http://www.wellmark.com) for the Wellmark Drug List for current medication tier levels and updated PA Forms

### Facsimile Transmittal Sheet

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

To: Wellmark Pharmacy Services

From (Prescriber's Name): \_\_\_\_\_

Fax Number: (866) 884-4345

Prescriber's DEA Number: \_\_\_\_\_

Phone Number: (800) 600-8065

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. Please provide the diagnosis this therapy has been prescribed for: \_\_\_\_\_

ICD-9 Code: \_\_\_\_\_

2. Has the patient failed therapy with trazodone immediate-release for the treatment of major depressive disorder (MDD)?  Yes  No

3. Is the patient taking other oral medication(s) more than once daily?  Yes  No

4. Is there a reason why the patient is unable to take medication(s) multiple times per day?  Yes  No

5. If yes, please provide the reason(s): \_\_\_\_\_

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Signature

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