

Cymbalta-Pristiq Step Therapy

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueChoice® HealthPlan

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax back to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant secure location.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program.

Caremark is an independent company that administers prescription drug benefits.

1. Is the prescribing physician a psychiatrist?
[If the answer to this question is no, skip to question 4.] Y N
2. Is there a history of intolerance, significant adverse reaction or non-response to either generic SSRIs, SNRIs, Lexapro or Effexor XR?
[If answer to this question is yes, then no further questions required.] Y N
3. Is the prescribing physician willing to prescribe an appropriate generic SSRI, SNRI, Lexapro or Effexor XR?
[No further questions required.] Y N
4. Has the patient been hospitalized for psychiatric reasons in the last 30 to 60 days?
[If the answer to this question is yes, then no further questions are required.] Y N
5. Is there a history of intolerance, significant adverse reaction or non-response to either generic SSRIs, SNRIs, Lexapro or Effexor XR?
[If answer to this question is yes, then no further questions required.] Y N
6. Is the medication being prescribed Cymbalta?
[If the answer to this question is no, then no further questions are required.] Y N
7. Does the patient have a diagnosis of diabetic peripheral neuropathy?
[If the answer to this question is yes, then no further questions are required.] Y N

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8. Does the patient have a diagnosis of fibromyalgia?

 Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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