



Prior Authorization Request Form – Selective Serotonin Reuptake Inhibitors (SSRIs)

Instructions:

This form is to be used by participating providers to request coverage for Selective Serotonin Reuptake Inhibitor (SSRI) medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
 P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
 Fax: 1-800-918-7542

A selective serotonin reuptake inhibitor (SSRI) step therapy program has been developed to encourage the use of first-line therapies before second.

<p>First-line therapies: citalopram tabs/solution fluoxetine 10mg caps/tabs fluoxetine 20mg caps fluoxetine solution fluvoxamine sertraline tabs/solution paroxetine tabs/solution</p>	<p>Second-line therapies: Lexapro Luvox CR paroxetine CR Pexeva</p>
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Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB:(mm/dd/yy)
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4. Prescriber's FULL Name & Specialty: Mailing Address:	5. Contact Person at Office:
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6. Prescriber's FAX & Telephone Number: Fax: ())	Tel: ())
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7. Primary Diagnosis/Indication:	8. Is the member suicidal? <input type="checkbox"/> Yes <input type="checkbox"/> No
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9. Requested Drug:	10. Dose, Frequency and Duration of Requested Drug:
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11. Has the member been started and stabilized on the requested drug for at least 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No - If 'yes', duration of therapy = _____
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12. Has the member previously tried at least two of the following preferred therapies?			
Drug Name (please check all that apply)	Response (please check all that apply)		
<input type="checkbox"/> citalopram	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> fluoxetine	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> fluvoxamine	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> paroxetine	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy
<input type="checkbox"/> sertraline	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response	<input type="checkbox"/> allergy

13. Prescriber comments:

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

 Prescriber's signature

 Date