

Fetzima (levomilnacipran) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

NPI NUMBER: PHONE NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:					URGEI	
PHONE NUMBER: DATE OF BIRTH: STREET ADDRESS: CITY: STATE: ZIP CODE: PATIENT INSURANCE ID NUMBER: MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES: YOU ARE NOT THE PATIENT OF THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE DILLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERICAL/COMMON/DOC/TR-US/PHI. DISCLOSURE AUTHORIZATION PDE ATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): UTHORIZED REPRESENTATIVE'S PHONE NUMBER: PRESCRIBER INFORMATION LAST NAME: PRESCRIBER SPECIALTY: EMAIL ADDRESS: OEA NUMBER: PHONE NUMBER: DEA NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (If different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: QUANTITY: THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	MEMBER INFORMATION					
STREET ADDRESS: CITY: STATE: ZIP CODE: PATIENT INSURANCE ID NUMBER: MALE	LAST NAME:		FIRST NAM	ΛE:		
STATE: ZIP CODE: PATIENT INSURANCE ID NUMBER: MALE	PHONE NUMBER:		DATE OF E	IRTH:		
PATIENT INSURANCE ID NUMBER: MALE	STREET ADDRESS:		I			
MALE FEMALE HEIGHT (IN/CM): WEIGHT (LB/KG): ALLERGIES: YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE LUCOWING LINK: !!TTPS://MAGEILANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI DISCLOSURE AUTHORIZATION.PDE ATTIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): UTHORIZED REPRESENTATIVE'S PHONE NUMBER: PRESCRIBER INFORMATION LAST NAME: FIRST NAME: PRESCRIBER SPECIALTY: EMAIL ADDRESS: NPI NUMBER: DEA NUMBER: PHONE NUMBER: FAX NUMBER: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF QUANTITY: THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	CITY:	STATE:	STATE: ZIP CODE:			
YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE ILLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI. DISCLOSURE AUTHORIZATION.PDE ATIENT'S AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: PRESCRIBER INFORMATION LAST NAME: PRESCRIBER SPECIALTY: EMAIL ADDRESS: NPI NUMBER: PHONE NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	PATIENT INSURANCE ID I	NUMBER:				
ATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): UTHORIZED REPRESENTATIVE'S PHONE NUMBER: PRESCRIBER INFORMATION LAST NAME: PRESCRIBER SPECIALTY: EMAIL ADDRESS: NPI NUMBER: PHONE NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL: DATE THERAPY INITIATED:						
UTHORIZED REPRESENTATIVE'S PHONE NUMBER: PRESCRIBER INFORMATION LAST NAME: FIRST NAME: FIRST NAME: PRESCRIBER SPECIALTY: EMAIL ADDRESS: DEA NUMBER: FAX NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:						
LAST NAME: PRESCRIBER SPECIALTY: EMAIL ADDRESS: NPI NUMBER: DEA NUMBER: PHONE NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL: DATE THERAPY INITIATED:	UTHORIZED REPRESENTA	ATIVE'S PHONE NUME				
PRESCRIBER SPECIALTY: EMAIL ADDRESS: DEA NUMBER: PHONE NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	PRESCRIBER INFORMATI	ON				
NPI NUMBER: PHONE NUMBER: FAX NUMBER: STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	LAST NAME:		FIRST NAM	FIRST NAME:		
PHONE NUMBER: STREET ADDRESS: CITY: STATE: STATE: CIP CODE: OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	PRESCRIBER SPECIALTY:		EMAIL AD	EMAIL ADDRESS:		
STREET ADDRESS: CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	NPI NUMBER:		DEA NUM	DEA NUMBER:		
CITY: STATE: ZIP CODE: REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	PHONE NUMBER:		FAX NUM	FAX NUMBER:		
REQUESTOR (if different than prescriber): OFFICE CONTACT PERSON: MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: INEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	STREET ADDRESS:		1			
MEDICATION OR MEDICAL DISPENSING INFORMATION MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	CITY:	STATE:	STATE: ZIP CODE:			
MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	REQUESTOR (if different than prescriber):		OFFICE CO	OFFICE CONTACT PERSON:		
MEDICATION NAME: DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:			,			
DOSE/STRENGTH: FREQUENCY: LENGTH OF THERAPY/REFILLS: RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	MEDICATION OR MEDIC	AL DISPENSING INFOR	RMATION			
THERAPY/REFILLS: NEW THERAPY RENEWAL IF RENEWAL: DATE THERAPY INITIATED:	MEDICATION NAME:					
	DOSE/STRENGTH:	FREQUENCY:			QUANTITY:	
DURATION OF THERAPY (SPECIFIC DATES):			/AL IF RENEW	AL: DATE TH	HERAPY INITIATED:	

© 2017 – 2023 by Magellan Rx Management, LLC. All Rights Reserved.

Revision Date: 08/22/2018

CAT0087







Fetzima (levomilnacipran) Prior Authorization Request Form



Caterpillar Prescription Drug Benefit Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME:	AME: MEMBER'S FIRST NAME:						
1. HAS THE PATIENT TRIED ANY OTHER	R MEDICATIONS FOR THIS CONDITION?	YES (if yes, complete below) NO					
MEDICATION/THERAPY (SPECIFY	DURATION OF THERAPY (SPECIFY	RESPONSE/REASON FOR					
DRUG NAME AND DOSAGE):	DATES):	FAILURE/ALLERGY:					
Broad William Book GE	5/(123):	THE ONLY FILLE NOTE					
2. LIST DIAGNOSES:		ICD-10:					
	: PLEASE PROVIDE ALL RELEVANT CLINIC	AL INFORMATION TO SUPPORT A					
PRIOR AUTHORIZATION.							
Is the patient 18 years of age or older?	P □ Yes □ No						
Does the patient have a diagnosis of major depressive disorder (MDD)? ☐ Yes ☐ No							
•	equate response, intolerance, or contrai						
generic SSRIs / SNRIs such as sertraline, duloxetine, citalopram, paroxetine, fluoxetine, fluvoxamine, escitalopram,							
or venlafaxine?* □ Yes □ No							
*Please provide documentation of treatment failure, intolerance, or contraindication.							
Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the							
physician feels is important to this review?							
Please note: Not all drugs/diagnosis are	e covered on all plans. This request may	be denied unless all required					
information is received.							
ATTESTATION: I attest the information	n provided is true and accurate to the be	st of my knowledge. I understand that					
the Health Plan, insurer, Medical Group	o or its designees may perform a routine	audit and request the medical					
information necessary to verify the acc	uracy of the information reported on thi	is form.					
Book the Charles of the	A. C.	P. L.					
Prescriber Signature or Electronic I.D.		Date:					
	ompanying this transmission contain confidential by notified that any disclosure, copying, distribute						
	have received this information in error, please no						

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program

Attn: CP - 4201 P.O. Box 64811 St. Paul, MN 55164-0811

 $\hbox{@ 2017-2023}$ by Magellan Rx Management, LLC. All Rights Reserved.

and arrange for the return or destruction of these documents.

Revision Date: 08/22/2018

CAT0087



