

# Drug Coverage Review Request

## State of NC Effexor XR and Pristiq - Prior Authorization

35045



### SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

#### PRESCRIBER

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

#### PATIENT

Cardholder's ID# \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

### SECTION A Please answer the following questions

1. Specify the NAME and STRENGTH of the prescribed medication: \_\_\_\_\_

2.  Yes  No Is the patient less than 18 years of age?

Note: Answer Questions 2 - 5 if patient is 18 years of age or older.

3.  Yes  No Has the patient previously demonstrated a response with the requested agent?

4.  Yes  No If the prescribed medication is **Effexor XR**, has the patient experienced FAILURE OR INTOLERANCE with at least **ONE** PREFERRED AGENT [for example, generic venlafaxine immediate release, a generic SSRI (such as citalopram, fluoxetine, paroxetine, sertraline) OR **Cymbalta**]?

5.  Yes  No If the prescribed medication is **Pristiq**, is the diagnosis depression?

6.  Yes  No If the prescribed medication is **Pristiq**, has the patient experienced FAILURE OR INTOLERANCE with at least **TWO** other preferred antidepressants, for example, generic venlafaxine immediate release, **Cymbalta**, generic bupropion SR or XL, or generic SSRI (such as citalopram, fluoxetine, paroxetine, sertraline)?

### SECTION B Physician signature

PHYSICIAN SIGNATURE

DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada (15) Case Id: 9999999



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Form 8932 (8932 & 8933 ) 07/2008

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FORM# FL921565

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