



Commonwealth of Massachusetts  
**MassHealth Drug Utilization Review Program**  
 P.O. Box 2586  
 Worcester, MA 01613-2586

**Fax:** 1-877-208-7428 **Phone:** 1-800-745-7318

## Antidepressant Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Celexa, Effexor, Effexor XR, Lexapro, mirtazapine orally disintegrating tablets, paroxetine for members < 18 yrs of age, Paxil CR, Pexeva, Prozac Weekly, Remeron Soltab, Sarafem, Zoloft, Wellbutrin XL, and brand-name multiple-source antidepressants that have an FDA "A"-rated generic equivalent. PA is not needed for amoxapine, bupropion, fluoxetine, fluvoxamine, MAOIs, maprotiline, mirtazapine, nefazadone, paroxetine for members > 18 years of age, trazodone, tricyclic antidepressants, or Wellbutrin SR. Additional information about antidepressants can be found within the MassHealth Drug List at [www.mass.gov/masshealth](http://www.mass.gov/masshealth).

### Member information

|                             |            |                               |   |               |                                 |
|-----------------------------|------------|-------------------------------|---|---------------|---------------------------------|
| Last name                   | First name | MI                            | MassHealth member ID no.                  | Date of birth | Sex (Circle one.)<br><b>f m</b> |
| Member's place of residence |            | <input type="checkbox"/> home | <input type="checkbox"/> nursing facility |               |                                 |

### Medication information

|  |  |
|--|--|
| <b>Antidepressant request</b><br><br><input type="checkbox"/> Celexa<br><input type="checkbox"/> Effexor<br><input type="checkbox"/> Effexor XR<br><input type="checkbox"/> Lexapro<br><input type="checkbox"/> mirtazapine orally disintegrating tablet<br><input type="checkbox"/> paroxetine for member <18 yrs of age<br><input type="checkbox"/> Paxil CR<br><input type="checkbox"/> Pexeva<br><input type="checkbox"/> Prozac Weekly<br><input type="checkbox"/> Remeron Soltab<br><input type="checkbox"/> Sarafem<br><input type="checkbox"/> Zoloft<br><input type="checkbox"/> Wellbutrin XL<br><input type="checkbox"/> Brand Name _____<br><input type="checkbox"/> Other _____ | Dose, frequency, and duration of requested drug _____<br>Drug NDC (if known) _____<br><br>Indication for antidepressant requested (Check all that apply.)<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Obsessive-compulsive disorder<br><input type="checkbox"/> Other (describe): _____<br>_____<br>_____<br><br>Please list all other psychotropic medications currently prescribed for the member.<br>_____<br>_____<br>_____ |
| Has member been hospitalized for this condition?<br><input type="checkbox"/> Yes. Dates of most recent hospitalization _____ <input type="checkbox"/> No   |  |
| Is member under the care of a psychiatrist? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Name of psychiatrist _____ Telephone no. _____<br>Date of last visit or consult with psychiatrist _____  |  |

## Medication information continued

Has member tried fluoxetine, fluvoxamine, or paroxetine?

Yes. Complete box A.

No. Explain why not.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has member previously tried requested antidepressant?

Yes. Complete box B.

No.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### A. Drug name

Dates of use

Dose and frequency

Did member experience any of the following?

Adverse reaction     Inadequate response     Intolerance     Other

Concern about drug interaction with \_\_\_\_\_

Briefly describe details of adverse reaction, inadequate response, intolerance, or other.

\_\_\_\_\_

\_\_\_\_\_

**Note:** You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

### B. Drug name

Dates and length of use

Maximum daily dose

Briefly describe how member responded to the requested antidepressant.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Note:** You may be asked to provide supporting documentation (e.g., copies of medical records, office notes, and/or completed FDA MedWatch form).

## Pharmacy information

|         |                       |                         |                   |
|---------|-----------------------|-------------------------|-------------------|
| Name    | Pharmacy provider no. | Telephone no.<br>(    ) | Fax no.<br>(    ) |
| Address |                       | City                    | State    Zip      |

## Prescriber information

|                |            |    |                         |                   |
|----------------|------------|----|-------------------------|-------------------|
| Last name      | First name | MI | MassHealth provider no. | DEA no.           |
| Address        |            |    | City                    | State    Zip      |
| E-mail address |            |    | Telephone no.<br>(    ) | Fax no.<br>(    ) |

## 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 (Stamp not accepted.)

\_\_\_\_\_  
Date