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.

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Antidepressant request

- ☐ Celexa
- ☐ Effexor
- ☐ Effexor XR
- ☐ Lexapro
- ☐ mirtazapine orally disintegrating tablet
- ☐ paroxetine for member <18 yrs of age
- ☐ Paxil CR
- ☐ Pexeva
- ☐ Prozac Weekly
- ☐ Remeron Soltab
- ☐ Sarafem
- ☐ Zoloft
- ☐ Wellbutrin XL
- ☐ Brand Name
- ☐ Other_____

Dose, frequency, and duration of requested drug

Drug NDC (if known)

Indication for antidepressant requested (Check all that apply.)

☐ Depression ☐ Panic disorder
☐ Obsessive-compulsive disorder ☐ Premenstrual dysphoric disorder
☐ Other (describe): _____

Please list all other psychotropic medications currently prescribed for the member.

Has member been hospitalized for this condition?

☐ Yes. Dates of most recent hospitalization _____ ☐ No

Is member under the care of a psychiatrist? ☐ Yes ☐ No

Name of psychiatrist _____ Telephone no. _____

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. ( )	Fax no. ( )	
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. ( )	Fax no. ( )	

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