UnitedHealthcare
Community Plan

Antidepressants - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ________________

Section B - Provider Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible):	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _______________**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

□ Yes □ No	**Is the patient transitioning from one antidepressant to another or will the patient remain on both medications?** *(If yes, check which applies)* □ Patient will remain on both medications *List medications that are being used together:* □ Transitioning from one antipsychotic to another *List medication that will be stopped and date it will be stopped:*
□ Yes □ No	**Will the patient remain on five or more psychotropic/mental health medications or is the patient titrating/changing medications and will be on less than five psychotropic/mental health medications?** *(Check which applies)* □ Patient will remain on five or more psychotropic medications □ Transitioning medications AND will be on LESS THAN five psychotropic medications *List drugs that will be stopped and date they will be stopped:*
□ Yes □ No	**Is the patient currently on the requested drug?** *If yes, list start date:*
□ Yes □ No	**Is the patient currently receiving treatment with the requested non-preferred behavioral health medication in the hospital and must continue upon discharge?** *If yes, list start date and discharge date:*
□ Yes □ No	**Does the patient have a history of failure, contraindication or intolerance to any alternatives from at least two of the following classes:** *(If yes, check which applies and complete Section D above)* □ Alpha-2 Receptor Antagonists (Tetracyclics) □ Norepinephrine-Dopamine Reuptake Inhibitors □ Selective Serotonin-Norepinephrine Reuptake Inhibitor (SNRI) □ Selective Serotonin Reuptake Inhibitor (SSRI) □ Serotonin Modulators
□ Yes □ No	**Do both of the following apply to the patient:** □ Trial of two preferred products, other than the generic equivalent to the requested brand □ Trial of the generic equivalent of the product being requested from 5 manufacturers. (If fewer than 5 manufacturers, must try all manufacturers)

Medications	Trail Dates	Generic Manufacturer

SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)

□ Yes □ No	**Is the patient using the requested medication with a Selective Serotonin Reuptake Inhibitor (SSRI), Serotonin Norepinephrine Reuptake Inhibitor (SNRI), or Serotonin Modulator–Miscellaneous (SMM)?** *(If yes, complete Section D above)*

TETRACYCLIC ANTIDEPRESSANTS

□ Yes □ No	**Is the patient using the requested medication with an Alpha-2 Receptor Antagonists–Tetracyclics (TeCA), Norepinephrine–Dopamine Reuptake Inhibitor (NDRI), Serotonin Norepinephrine Reuptake Inhibitor (SNRI), or Serotonin Modulator–Miscellaneous (SMM)?** *(If yes, complete Section D above)*

NDRI (BUPROPION)

□ Yes □ No	**Is the patient using the requested medication with another Norepinephrine-Dopamine Reuptake Inhibitor (NDRI) or an Alpha-2 Receptor Antagonists-Tetracyclics (TeCA)?** *(If yes, complete Section D above)*

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SEROTONIN MODULATOR–MISCELLANEOUS (SMM)	
□ Yes □ No	**Is the patient using the requested medication with a Selective Serotonin Reuptake Inhibitor (SSRI), Alpha-2 Receptor Antagonists-Tetracyclics (TeCA), Serotonin Norepinephrine Reuptake Inhibitor (SNRI), or Serotonin Modulator-Miscellaneous (SMM)?** *(If yes, complete Section D above)*
SEROTONIN NOREPINEPHRINE REUPTAKE INHIBITOR (SNRI)	
□ Yes □ No	**Is the patient using the requested medication with a Selective Serotonin Reuptake Inhibitor (SSRI), Alpha-2 Receptor Antagonists-Tetracyclics (TeCA), Serotonin Norepinephrine Reuptake Inhibitor (SNRI), or Serotonin Modulator-Miscellaneous (SMM)?** *(If yes, complete Section D above)*
CONTINUATION OF THERAPY	
□ Yes □ No	**Is there documentation of positive clinical response to treatment?** *If yes, list response:*

Provider Signature: ____ **Date:** ____________________

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