# Prior Authorization Form: **Brintellix and Viibryd**

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

| Office Contact: | Provider Specialty: | |
|---|---|---|
| Provider First Name: | Provider Last Name: | |
| Provider Phone: | Provider Fax: | Provider NPI #: |

| Patient Name: | CCHP Member ID Number: | Patient DOB: | Patient Age: |
|---|---|---|---|

| Drug Requested:<br>**Brand** **Generic** | Strength: | Frequency: | Qty Dispensed: |
|---|---|---|---|

**Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.**

| **New medication**<br>**Ongoing medication** | If ongoing, provide date started: | If medication is ongoing, did member show improvement while on therapy? | Yes<br>No |
|---|---|---|---|

| Diagnosis: | Date of diagnosis: |
|---|---|

## Medical history

**Please indicate if the member previously tried and failed any of the following medications:**

| Medication | Strength | Frequency | Start date | End date | Reason for failure or discontinuation |
|---|---|---|---|---|---|
| Citalopram (Celexa) | | | | | |
| Escitalopram (Lexapro) | | | | | |
| Fluoxetine (Prozac) | | | | | |
| Paroxetine (Paxil) | | | | | |
| Sertraline (Zoloft) | | | | | |
| Venlafaxine (Effexor) | | | | | |
| Other (please provide name): | | | | | |

| Question | Answer |
|---|---|
| Is the member currently taking any Monoamine Oxidase Inhibitors (such as phenylzine, selegiline, tranylcypromine, or Azilect)? | **Yes** **No** |
| If yes, will this medication be discontinued at least 14 days before the requested medication is started? | **Yes** **No** |
| Is the member currently taking linezolid or intravenous methylene blue? | **Yes** **No** |

**Please provide any additional information which should be considered in the space below:**