US Family Health Plan
Prior Authorization Request Form for
levomilnacipran XR (**Fetzima**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the patient GREATER THAN or EQUAL TO 18 years of age?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. Does the provider acknowledge that the patient and provider have discussed that non-pharmacologic interventions (for example, cognitive- behavioral therapy (CBT), sleep hygiene) are encouraged to be used in conjunction with this medication?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Is the requested drug being used for the treatment of depression?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**

4. Does the patient have a contraindication to, intolerability to, or has failed a trial of THREE formulary antidepressant medications for example: • **SSRIs** (selective serotonin reuptake inhibitors, for example, citalopram, escitalopram, fluoxetine, paroxetine, sertraline), • **SNRIs** (serotonin/norepinephrine reuptake inhibitors, for example, venlafaxine, duloxetine; not including milnacipran), • **tricyclic antidepressants** (TCAs, for example, amitriptyline, desipramine, imipramine, nortriptyline), • **mirtazapine,** • **bupropion,** • **trazodone immediate-release,** • **nefazodone, and** • **monoamine oxidase inhibitors** (MAOIs)**?** • **Note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose.**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____