US Family Health Plan
Prior Authorization Request Form for
vortioxetine **(Trintellix)**

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 patient and provider have discussed that non-pharmacologic interventions (such as: 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 patient being treated for depression?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved

4. Does the patient has a contraindication to, intolerability to, or has failed a trial of TWO formulary antidepressant medications for example: • **selective serotonin reuptake inhibitor (SSRI) – (citalopram, escitalopram, fluoxetine), or** • **serotonin-norepinephrine reuptake inhibitor (SNRI) – (venlafaxine IR, venlafaxine ER, desvenlafaxine succinate ER).** • **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