

US Family Health Plan
 Prior Authorization Request Form for
 vilazodone (**Viibryd**)

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: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete the clinical assessment:

1. Is the patient GREATER THAN or EQUAL TO 18 years of age?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No STOP Coverage not approved
3. Is the requested drug being used for the treatment of depression?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved

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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

[28 December 2022]