



Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ()	
BCBSLA Provider Number		Area of Practice/Specialty		Phone Number ()	

REQUESTED DRUG*

<input type="checkbox"/> Celexa®	<input type="checkbox"/> Luvox CR®	<input type="checkbox"/> Prozac Weekly®
<input type="checkbox"/> Cymbalta®	<input type="checkbox"/> Paxil®	<input type="checkbox"/> Sarafem®
<input type="checkbox"/> Effexor®	<input type="checkbox"/> Paxil CR®	<input type="checkbox"/> Venlafaxine ER® (Tablets)
<input type="checkbox"/> Effexor® XR	<input type="checkbox"/> Pexeva®	<input type="checkbox"/> Viibryd®
<input type="checkbox"/> Lexapro®	<input type="checkbox"/> Pristiq®	<input type="checkbox"/> Zoloft®
<input type="checkbox"/> Luvox®	<input type="checkbox"/> Prozac®	<input type="checkbox"/> Other _____

INDICATION / DIAGNOSIS

<input type="checkbox"/> Diabetic Peripheral Neuropathic Pain (DPN)	<input type="checkbox"/> Neuropathic Pain (not related to DPN)
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Premenstrual Dysphoric Disorder (PMDD)
<input type="checkbox"/> Hot Flashes	<input type="checkbox"/> Stress Urinary Incontinence
<input type="checkbox"/> Musculoskeletal Pain	

PAST TREATMENT HISTORY (Check ALL that apply)

<input type="checkbox"/> Anticonvulsants (i.e. gabapentin, carbamazepine, oxcarbazepine)	<input type="checkbox"/> Luvox®	<input type="checkbox"/> Prozac®
<input type="checkbox"/> Citalopram	<input type="checkbox"/> Luvox CR®	<input type="checkbox"/> Prozac Weekly®
<input type="checkbox"/> Celexa®	<input type="checkbox"/> Lyrica® (pregabalin)	<input type="checkbox"/> Selfemra™
<input type="checkbox"/> Cox-2 Inhibitor (Celebrex®)	<input type="checkbox"/> Mexitil® (mexiletine)	<input type="checkbox"/> Sertraline
<input type="checkbox"/> Cymbalta®	<input type="checkbox"/> NSAIDs	<input type="checkbox"/> Tricyclic Antidepressants (i.e. imipramine, amitriptyline)
<input type="checkbox"/> Effexor®	<input type="checkbox"/> Opioids	<input type="checkbox"/> Ultram® (tramadol)
<input type="checkbox"/> Effexor XR®	<input type="checkbox"/> Paroxetine	<input type="checkbox"/> Venlafaxine
<input type="checkbox"/> Escitalopram	<input type="checkbox"/> Paroxetine CR	<input type="checkbox"/> Venlafaxine ER® (Tablets)
<input type="checkbox"/> Flexeril® (cyclobenzaprine)	<input type="checkbox"/> Paxil®	<input type="checkbox"/> Venlafaxine ER (Generic Capsules)
<input type="checkbox"/> Fluoxetine	<input type="checkbox"/> Paxil CR®	<input type="checkbox"/> Zoloft®
<input type="checkbox"/> Fluvoxamine	<input type="checkbox"/> Pexeva®	<input type="checkbox"/> Other _____
<input type="checkbox"/> Lexapro®	<input type="checkbox"/> Pristiq®	

OTHER CLINICAL INFORMATION (Check ALL that apply)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have suicidal ideation?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Was the patient previously on the requested medication?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient currently taking the requested medication in the form of samples and is stabilized on therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient been paying 100% out of pocket for the requested medication for at least 4 weeks and is stabilized on therapy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the medication being prescribed for a psychiatric condition?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the prescribing physician a psychiatrist?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient ≤ 18 years of age?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient a female who is also taking tamoxifen?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient a male with androgen deprivation associated with prostate cancer?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there clinical evidence or patient history that suggests the step 1 medication will be ineffective or cause an adverse reaction to the patient? _____

PHYSICIAN SIGNATURE _____ Prescribing Physician	DATE _____
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*Preferred brand drugs (Tier 2) are designated in bold.
Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed