



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"/> Cymbalta® <input type="checkbox"/> Effexor® <input type="checkbox"/> Effexor® XR <input type="checkbox"/> Lexapro®	<input type="checkbox"/> Luvox® <input type="checkbox"/> Luvox CR® <input type="checkbox"/> Paxil® <input type="checkbox"/> Paxil CR® <input type="checkbox"/> Pexeva® <input type="checkbox"/> Pristiq®	<input type="checkbox"/> Prozac® <input type="checkbox"/> Prozac Weekly® <input type="checkbox"/> Sarafem® <input type="checkbox"/> Venlafaxine ER® <input type="checkbox"/> Zoloft® <input type="checkbox"/> Other _____
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INDICATION / DIAGNOSIS

Diabetic Peripheral Neuropathic Pain (DPN)
 Fibromyalgia
 Hot Flashes
 Neuropathic Pain (not related to DPN)
 Premenstrual Dysphoric Disorder (PMDD)
 Stress Urinary Incontinence

PAST TREATMENT HISTORY (Check ALL that apply)

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

Yes No Does the patient have suicidal ideation?
 Yes No Was the patient previously on the requested medication?
 Yes No Is the patient currently taking the requested medication in the form of samples and is stabilized on therapy?
 Yes No Has the patient been paying 100% out of pocket for the requested medication for at least 4 weeks and is stabilized on therapy?
 Yes No Is the medication being prescribed for a psychiatric condition?
 Yes No Is the prescribing physician a psychiatrist?
 Yes No Is the patient ≤ 18 years of age?
 Yes No Is the patient a female who is also taking tamoxifen?
 Yes No Is the patient a male with androgen deprivation associated with prostate cancer?

PHYSICIAN SIGNATURE _____ Prescribing Physician	DATE _____
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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