



# Prior Authorization Request Form Non-formulary Antidepressants



**\*\*SENSITIVE BUT UNCLASSIFIED\*\***

This form is to be completed and signed by the CCE Medical Director and should only be used for prescriptions to be filled through the World Trade Center Health Program (WTCHP).

The CCE should upload this completed form into VitalPoint and inform the PBM and the WTCHP of this request via the SAMS messaging system.

**Please provide the following member and prescriber information (please print):**

Member Name: _____	Prescriber Name: _____
Member ID: _____	Prescriber Address: _____
CCE: _____	_____
Requested Medication: _____	Prescriber Phone #: _____

**Please complete the following clinical assessment:**

- |   |   |  |
|---|---|--|
| <p><b>1.</b> Is the member being treated for a WTC Health Program covered mental health condition?</p>  | <p>Yes<br/><b>Proceed to question 2</b></p>                           | <p>No<br/><b>Coverage not approved</b></p> |
| <p><b>2.</b> Has the member previously responded to the requested non-formulary medication and changing to a formulary medication would introduce unacceptable clinical risk(s) to the member?</p>                                    | <p>Yes<br/><b>Sign and date below</b></p>                             | <p>No<br/><b>Proceed to question 3</b></p> |
| <p><b>3.</b> Has the member failed a formulary medication from at least 2 different categories OR has the member failed a formulary medication from at least 1 category and has a contraindication for at least 1 other category?</p> | <p>Yes<br/><b>Indicate reasons in box and sign and date below</b></p> | <p>No<br/><b>Coverage not approved</b></p> |

Please circle the reason(s) why the member cannot be treated with the following formulary medications:

1. Use of formulary medication(s) is contraindicated.
2. Member has experienced significant adverse effects from formulary medication(s).
3. Use of formulary medication(s) has resulted in a therapeutic failure.

**Monoamine Oxidase Inhibitor**

Isocarboxazid (Marplan)	1	2	3
Phenelzine (Nardil)	1	2	3
Selegiline Patch (Emsam)	1	2	3
Tranylcypromine (Parnate)	1	2	3

**Serotonin Norepinephrine Reuptake Inhibitors**

Duloxetine (Cymbalta)	1	2	3
Venlafaxine (Effexor)	1	2	3

**Selective Serotonin Reuptake Inhibitors**

Citalopram (Celexa)	1	2	3
Escitalopram (Lexapro)	1	2	3
Fluoxetine (Prozac)	1	2	3
Fluvoxamine (Luvox)	1	2	3
Paroxetine (Paxil)	1	2	3
Sertraline (Zoloft)	1	2	3

**Tricyclic Antidepressants**

Amitriptyline (Elavil)	1	2	3
Clomipramine (Anafranil)	1	2	3
Desipramine (Norpramin)	1	2	3
Doxepin (Sinequan)	1	2	3
Imipramine (Tofranil)	1	2	3
Nortriptyline (Pamelor)	1	2	3
Protriptyline (Vivactil)	1	2	3

**Misc**

Bupropion (Wellbutrin, Aplenzin)	1	2	3
Mirtazapine (Remeron)	1	2	3
Nefazodone (Serzone)	1	2	3
Trazodone (Desyrel)	1	2	3
Vilazodone (Vibryd)	1	2	3
Vortioxetine (Trintellix)	1	2	3

**TO BE FILLED OUT BY  
WTC HEALTH PROGRAM**

Decision:  
Decision Comments:

By signing below, I certify that the above information is correct and accurate to the best of my knowledge.

WTCHP (NIOSH) Signature	Date
CCE/NPN Medical Director (or Designee) Signature	Date

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