AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Marplan® (isocarboxazid)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Maximum Dose: 60 mg per day

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must be 18 years of age or older
- ❑ Medication is prescribed by or in consultation with a psychiatrist
- ❑ Member has a diagnosis of depression

(Continued on next page)

- ❑ Member has had an unsuccessful trial of at least **2 oral antidepressant medications from 2 different drug classes (Check all that apply; Trials MUST have been for a minimum of 6 weeks for each medication; Treatment failure will be verified by chart notes and/or pharmacy paid claims)**:

❑ sertraline	❑ escitalopram	❑ fluoxetine
❑ citalopram	❑ paroxetine	❑ venlafaxine ER
❑ bupropion	❑ desvenlafaxine ER	❑ duloxetine
❑ mirtazepine	❑ other (please note): _____	

- ❑ Member will **NOT** take any of the following in conjunction with the requested medication: SSRIs, SNRIs, other MAOIs, tricyclic antidepressants, bupropion, buspirone, mirtazapine, sympathomimetic amines (e.g., amphetamines, methylphenidate, dextroamphetamine), cyclobenzaprine, selegiline, meperidine, tramadol, methadone, dextromethorphan, St. John's wort, carbamazepine or oxcarbazepine
- ❑ Member will follow a tyramine-restricted diet (i.e. abstain from eating air dried/aged/fermented meats, sausages and salamis, fava beans, aged cheeses, tap beer and beers that have not been pasteurized, sauerkraut, most soybean products including soy sauce and tofu, and OTC supplements containing tyramine)

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*