CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: **Pristiq *(Pristiq, Desvenlafaxine, ER and Khedezla)***

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly. Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:	
Provider First Name:		Provider Last Name:	
Provider Phone #:		Provider Fax #:	Provider NPI #:
Patient Name:	CCHP Member ID #:	Patient DOB:	Patient Age:
Drug Requested: **Brand Generic**	Strength:	Frequency:	Quantity Dispensed (including units):

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	☐ **Yes** ☐ **No**
Diagnosis:		Date of Diagnosis:	

Medical History

Please indicate if the member previously tried and failed any of the following medications:

Medication	Strength	Frequency	Start date	End date	Reason for failure or discontinuation
Citalopram (Celexa)					
Escitalopram (Lexapro)					
Fluoxetine (Prozac)					
Paroxetine (Paxil)					
Sertraline (Zoloft)					
Venlafaxine (Effexor)					
Other (please provide name):					

Please provide any additional clinical information which should be considered in the space below: