Excellus

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Mental Health Prior Authorization Request FAX Form

FAX: 1-800-956-2397

Please complete all of the following Patient/Physician Information:

Patient Name: (Please Print)	
FLRx Patient ID number:	**Patient Birthdate:**
MD Name:	**MD Specialty:**
MD Phone #: ( )	**MD FAX #: ( )**
MD DEA #:	**MD NPI#:**

Drug Requested:

Antidepressants	☐ Aplenzin ☐ Brintellix ☐ Desvenlafaxine ER ☐ Emsam ☐ Fetzima ☐ Forfivo XL ☐ Khendezla ☐ Luvox CR ☐ Pexeva ☐ Pristiq ☐ Oleptro ☐ Other ___________
Antipsychotics	☐ Abilify ☐ Fanapt ☐ Invega ☐ Latuda ☐ Saphris ☐Seroquel XR ☐ Other ________________

Strength: **Directions for use:**

Is this patient a: ☐ **New start** **or** ☐ **Continued treatment** **Start date:** _____________

Mental Health Diagnosis: ☐ **Depression** ☐ **Bipolar Depression** ☐ **Bipolar II Disorder** ☐ **Anxiety** ☐ **Schizophrenia** ☐ **Bipolar I Disorder** ☐ **Other** _____________________

Antidepressants				**Atypical Antispsychotics**			
Previous Therapies	**Reason for D/C**	**From:**	**To:**	**Previous Therapies**	**Reason for D/C**	**From:**	**To:**
☐ citalopram				☐ Invega			
☐ fluoxetine				☐ Risperdal			
☐ paroxetine				☐ Seroquel/XR			
☐ sertraline				☐ Zyprexa			
☐ escitalopram				☐ Abilify			
☐ mirtazapine				☐ Geodon			
☐ venlafaxine ER				☐ Other:			
☐ buproprion SR							
☐ buproprion XL							
☐ Cymbalta							
☐ None							
☐ Other :							

Explanation of Medical Necessity:

I certify that the above information is true and accurate to the best of my knowledge.

To avoid processing delays, please add your electronic signature below or print this document and provide your handwritten signature.

Prescriber Signature ____________________________ Date ________________

***FOR QUESTIONS OR HELP WITH COMPLETING THIS FORM CALL:* 1-800-724-5033**
***URGENT REQUESTS ONLY:* 1-800-208-4050 (fax)**