

**FORWARDHEALTH
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR STEP THERAPY FOR
CYMBALTA FOR MAJOR DEPRESSIVE DISORDER (MDD)**

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD) Completion Instructions, F-00284A. Providers may refer to the Forms page of the ForwardHealth Portal at www.forwardhealth.wi.gov/WIPortal/Content/provider/forms/index.htm.spage for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization/Preferred Drug List (PA/PDL) for Step Therapy for Cymbalta for Major Depressive Disorder (MDD) form signed by the prescriber before calling the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system or submitting a PA request on the Portal or on paper. Providers may call Provider Services at (800) 947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth — Member

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name
Cymbalta

5. Drug Strength

6. Date Prescription Written

7. Refills

8. Directions for Use

9. Name — Prescriber

10. National Provider Identifier (NPI) — Prescriber

11. Address — Prescriber (Street, City, State, ZIP+4 Code)

12. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

13. Diagnosis Code and Description

14. Does the member have a diagnosis of MDD?

Yes No

15. Is the member currently taking Cymbalta for MDD?

Yes No

Continued



DT-PA099-099

SECTION IIIA — CLINICAL INFORMATION FOR PREVIOUS USE OF PREFERRED SELECTIVE SEROTONIN REUPTAKE INHIBITOR DRUGS

16. Has the member previously taken a preferred selective serotonin reuptake inhibitor (SSRI) drug for MDD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? Yes No

If yes, check the name(s) of the preferred SSRI drug(s) the member has taken.

1. citalopram _____
2. fluoxetine _____
3. fluvoxamine _____
4. paroxetine _____
5. sertraline _____

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction(s) and the approximate dates the preferred SSRI drug(s) was taken on the line(s) adjacent to the drug name(s) above.

SECTION IIIB — CLINICAL INFORMATION FOR PREVIOUS USE OF BUPROPION OR VENLAFAXINE

17. Has the member taken any formulation of bupropion for MDD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? Yes No

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates bupropion was taken in the space provided.

18. Has the member taken any formulation of venlafaxine for MDD and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction? Yes No

If yes, indicate the specific details about the unsatisfactory therapeutic response or clinically significant adverse drug reaction and the approximate dates venlafaxine was taken in the space provided.

SECTION IIIC — CLINICAL INFORMATION FOR CURRENT USE OF CYMBALTA

19. Is the member currently taking Cymbalta for MDD for 30 days or more with a measureable therapeutic response? Yes No

20. Has the member taken drug company-provided samples of Cymbalta in the past 30 days? Yes No

21. SIGNATURE — Prescriber	22. Date Signed
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SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

23. National Drug Code (11 Digits)	24. Days' Supply Requested (Up to 365 Days)
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25. NPI

26. Date of Service (MM/DD/CCYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to 14 days in the past.)

27. Place of Service

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA (Continued)

28. Assigned PA Number

29. Grant Date

30. Expiration Date

31. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

32. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the drug requested may also be included here.