



ANTIDEPRESSANT PRIOR AUTHORIZATION FORM

SD DEPARTMENT OF SOCIAL SERVICES MEDICAL SERVICES DIVISION

Fax Completed Form to:
866-254-0761
For questions regarding this
Prior authorization, call
866-705-5391

SD Medicaid requires that patients receiving a new prescription for a second tier antidepressant must fail a first tier agent.

- Tricyclics, trazodone, bupropion, citalopram, fluoxetine, mirtazapine, immediate release paroxetine, sertraline and venlafaxine do not require a prior authorization.
- Patients currently stabilized on a second generation antidepressant will not be asked to change medication.
- Escitalopram will not require a prior authorization for recipients under the age of 18.

Part I: RECIPIENT INFORMATION (To be completed by physician's representative or pharmacy):

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	

Part II: PHYSICIAN INFORMATION (To be completed by physician's representative or pharmacy):

PHYSICIAN NAME:	PHYSICIAN DEA NUMBER:
City:	PHONE: ()
	FAX: ()

Part III: TO BE COMPLETED BY PHYSICIAN:

Requested Drug and Dosage: (must be completed)
Diagnosis for this request:
Qualifications for coverage:
<input type="checkbox"/> One failed trial with an antidepressant from tier one.
1. List failed medication
Adverse Reaction (attach FDA MedWatch form) or contraindication: (provide description below):
Medical Justification for use of a tier two agent without trial of a tier one agent:
Physician Signature: _____ Date: _____

Part IV: PHARMACY INFORMATION

PHARMACY NAME:	SD MEDICAID PROVIDER NUMBER:
Phone: ():	FAX: ()
Drug:	NDC#:

Part V: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	