South Dakota Department of Social Services

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Auvelity® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Major depressive disorder

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

1. The patient is unresponsive to other treatment modalities, unless contraindicated (i.e. other medications or behavioral modification attempted) List all: _____
2. The physician attests that the requested medication is medically necessary. Document rationale for use: _____
3. Patient has a history of failure, contraindication or intolerance to at least 3 preferred alternatives* in the last 3 years:

❑ bupropion/SR/XL	❑ duloxetine	❑ fluvoxamine	❑ sertraline
❑ citalopram	❑ escitalopram	❑ mirtazapine	❑ trazodone
❑ desvenlafaxine ER	❑ fluoxetine	❑ paroxetine	❑ venlafaxine/ER
			❑ other _____

4. How long has the patient tried the above listed medications? _____

Quantity limit requests:

What is the quantity requested per MONTH? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes

❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)

❑ Requested strength/dose is not commercially available

❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.