

Brisdelle[™] Prior Authorization Request Form

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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 F		orm:
Check if requesting brand		Directions for Use:			
Check if request is for continuation of the					
Clinical Information (required)					
Medication history:					
Has the patient had a 60 day trial and failure of paroxetine oral tablets within the past 6 months? Tes No					

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.

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