

# Network Health Cymbalta (duloxetine) Prior Authorization Request

## Medication Request Form (MRF)

**Cymbalta (duloxetine)**

**FAX TO: (877) 501-1059**

**c/o MedImpact Healthcare Systems, Inc.**

Attn: Prior Authorization Department

10680 Treena Street, Suite 500, San Diego, CA 92131 - Phone: 1-800-788-2949

**Instructions:**

This form is to be used by participating providers to obtain coverage for the drugs listed above, which require prior authorization. Please complete this form and fax it to MedImpact Healthcare Systems, Inc. at (877) 501-1059. If you have any questions regarding this process, please contact MedImpact's Customer Service at (800) 788-2949.

**\*\*\* ONLY COMPLETED FORMS CAN BE PROCESSED \*\*\***

**Member/Provider Information:**

<b>Member's Name:</b>	<b>Prescriber's Name:</b>
<b>Member's Network Health ID #:</b>	<b>Prescriber's Specialty:</b>
<b>Member's DOB (mm-dd-yy):</b>	<b>DEA # (Required):</b> _____ <b>NPI #:</b> _____
<b>Pharmacy used by Member:</b>	<b>Prescriber's Telephone Number/ Contact Name:</b>
<b>Pharmacy (Area Code) Telephone Number:</b>	<b>Prescriber's (Area Code) Fax Number:</b>

**Clinical Information:**

<b>Dose and Quantity Requested:</b> _____														
<b>Documentation of Medical Necessity</b> (please check all that apply):														
<p>1. Is member currently stabilized on Cymbalta for at least 3 months or following recent hospitalization?          Taking for 3 months: <input type="checkbox"/> Yes    <input type="checkbox"/> No                      Taking since hospitalization: <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>2. Please indicate the member's diagnosis :  <input type="checkbox"/> Depression    <input type="checkbox"/> Anxiety Disorder    <input type="checkbox"/> Neuropathic pain/condition    <input type="checkbox"/> Fibromyalgia    <input type="checkbox"/> Other: _____</p> <p>3. Please indicate if the patient has had previous trials with the below agents or if the agent is contraindicated. Please check all that apply, and reason for discontinuation or contraindication:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; text-align: center;"><b>Specific agents</b></td> <td style="width: 50%; text-align: center;"><b>Reason for discontinuation or contraindication:</b></td> </tr> <tr> <td><input type="checkbox"/> SSRI : _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Tricyclic Antidepressant : _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Venlafaxine IR/ER/XR</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> other SNRI : _____</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Gabapentin</td> <td>_____</td> </tr> <tr> <td><input type="checkbox"/> Other Anticonvulsant : _____</td> <td>_____</td> </tr> </table> <p>4. The FDA-approved Cymbalta dosing schedule for the treatment of generalized anxiety disorder, diabetic peripheral neuropathic pain, fibromyalgia and the maintenance treatment of major depressive disorder, is once daily dosing. For quantities exceeding once daily dosing, please indicate necessity:  <input type="checkbox"/> Short term titration    length of treatment : _____  <input type="checkbox"/> Tried/Failed once daily dosing    date : _____</p>	<b>Specific agents</b>	<b>Reason for discontinuation or contraindication:</b>	<input type="checkbox"/> SSRI : _____	_____	<input type="checkbox"/> Tricyclic Antidepressant : _____	_____	<input type="checkbox"/> Venlafaxine IR/ER/XR	_____	<input type="checkbox"/> other SNRI : _____	_____	<input type="checkbox"/> Gabapentin	_____	<input type="checkbox"/> Other Anticonvulsant : _____	_____
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<input type="checkbox"/> Gabapentin	_____													
<input type="checkbox"/> Other Anticonvulsant : _____	_____													

**Request for expedited review (72 hours):** By checking this box, I certify that applying the standard review time frame may seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

**SIGNATURE**

I CERTIFY THAT THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE TO THE BEST OF MY KNOWLEDGE, AND I UNDERSTAND THAT ANY FALSIFICATION, OMISSION, OR CONCEALMENT OF MATERIAL FACT MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.

Prescriber's Signature (STAMP NOT ACCEPTED)

Date

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Contacted:
Provider:
Pharmacy:
Patient:

DO NOT WRITE IN SHADED AREAS FOR INTERNAL USE ONLY
Approved:
Denied:
Returned:
PA #