| Prescriber Criteria Form<br><br>Paxil Sus 2024 PA Fax 4617-A v1 010124.docx<br>Paxil Suspension (paroxetine hydrochloride)<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.<br>Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.<br>When conditions are met, we will authorize the coverage of Paxil Suspension (paroxetine hydrochloride). |

| Drug Name:<br>Paxil Suspension (paroxetine hydrochloride) |
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| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Is the requested drug being prescribed for the treatment of any of the following: A) major depressive disorder, B) obsessive compulsive disorder, C) panic disorder, D) social anxiety disorder, E) generalized anxiety disorder, F) posttraumatic stress disorder?<br>[If no, then no further questions.] | Yes | No |
| 2 | Is the patient unable to take solid oral dosage forms (e.g., difficulty swallowing tablets or capsules)? | Yes | No |

| Comments: | _____ |
|---|---|

| By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan. |
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| **Prescriber (or Authorized) Signature:** _____ **Date:**_____ |