Prescriber Criteria Form

Desvenlafaxine ER 2024 PA Fax 2485-A v1 010124.docx
Desvenlafaxine succinate extended-release tablets
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.
Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Desvenlafaxine succinate extended-release tablets.

Drug Name:
Desvenlafaxine succinate extended-release tablets

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 major depressive disorder (MDD)? [If no, then no further questions.]	Yes	No
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to TWO of the following: A) serotonin and norepinephrine reuptake inhibitors (SNRIs), B) selective serotonin reuptake inhibitors (SSRIs), C) mirtazapine, D) bupropion?	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.

Prescriber (or Authorized) Signature: _____ **Date:**_____