

Fax completed form to: 1-866-868-0858
Questions, please call: 1-866-316-6049



Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

Re: Emsam® (selegiline transdermal system): Prior Authorization Request Form: Please respond.

- Please complete the attached Emsam® (selegiline transdermal system) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

Please note: By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

Information about this drug

Emsam® (selegiline transdermal system)

The combination of MAOIs with foods containing high amounts of tyramine has been associated with hypertensive crisis. Data involving the 6mg/24hr patch suggests that dietary restrictions are not necessary; however, patients taking the 9mg/24hrs or 12mg/24hr patch should be counseled to avoid tyramine rich foods (e.g., aged cheeses, beer). See <http://www.emsam.com/pdf/medguide.pdf> for a full list.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 03/10/2008

Prior Authorization Request Form



Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

Patient Information

Name _____
Member ID _____
Medicare ID _____
Date of birth _____ Sex: M / F
Address _____
City _____
State _____ ZIP _____
Phone _____
Nursing home resident? YES / NO
Home care patient? YES / NO

Prescriber and Pharmacy Information

Name _____
Specialty _____
DEA _____
NPI _____
Address _____
City _____
State _____ ZIP _____
Phone _____ Fax _____
Pharmacy name _____
NCPDP _____
NPI _____
Phone _____ Fax _____

All items below this line are for Physician Use Only

Information for Requested Drug

Strength: _____ Dosage form: _____ Qty per 30 days: _____ Drug is (circle one): Newly prescribed/Refill
Directions: _____ Diagnosis: _____ ICD-9 Code: _____

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

Emsam® (selegiline transdermal system) Criteria

- Does the patient have a diagnosis of major depressive disorder?
 Yes No
 If No, please list indication for use: _____
- Please specify the diagnosis code(s) supporting the necessity for the requested agent. This question must be completed.
 ICD-9: _____
- Indicate strength of Emsam® patch requested
 9mg/ 24 hrs
 12mg/24hrs
 6mg/24 hrs
- Does the patient have any contraindications to Emsam® use or is receiving concomitant therapy with any of the following contraindicated medications or is scheduled for surgery requiring general anesthesia within 10 days?
 Yes No
 - antidepressants including SSRIs, SNRIs, tricyclic antidepressants; bupropion; mirtazapine, MAOIs
 - analgesic agents such as meperidine, tramadol, methadone, and propoxyphene
 - other drugs such as dextromethorphan, St. John's wort, cyclobenzaprine, oral selegiline, carbamazepine, oxycarbamazepine, or sympathomimetic amines
- Has the patient failed to receive a clinically appropriate therapeutic response OR demonstrated intolerance (e.g., allergy, adverse effect(s), development of a contraindication) from two (2) or more SSRIs (e.g. fluoxetine, paroxetine, sertraline, citalopram, escitalopram) AND one (1) SNRI (e.g., venlafaxine, duloxetine) AND one (1) other antidepressant (e.g., tricyclic antidepressant, bupropion, mirtazapine) over a period of 30 or more days for each drug?
 Yes No

Medical justification: (Attach additional page if necessary): _____

Prescriber's signature: _____ Date: _____