

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

**TODAY'S HEALTH**

**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

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

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- 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**

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**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.**

# 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: \_\_\_\_\_