

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

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

**GENERATIONS HEALTHCARE**

**Important Information About Prescription Drug Coverage**

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

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

Re: Nefazodone (Serzone®) Tablets: Prior Authorization Request Form: Please respond.

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- Please complete the attached Nefazodone (Serzone®) Tablets 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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**Nefazodone (Serzone®) Tablets**

Nefazodone has been found to produce one case of liver failure resulting in death or transplant per 250,000 to 300,000 patient-years. Please consider one of the following formulary alternatives before nefazodone if clinically appropriate: citalopram, fluoxetine, paroxetine, sertraline, mirtazapine, bupropion, nortriptyline, desipramine, Lexapro®.

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.

### Nefazodone (Serzone®) Tablets Criteria

- 1 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed.  
 depression (ICD-9: 296, 311)  
 other (diagnosis and ICD-9): \_\_\_\_\_
  - 2 Does patient have liver injury due to previous nefazodone treatment, active liver disease, or elevated serum transaminases?  
 Yes  No
  - 3 Has 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 antidepressants over a period of 30 or more days for each drug?  
 Yes  No
- Periodic liver function tests are required during nefazodone therapy.

Medical Justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_