**OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.**
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Effexor XR® and venlafaxine extended-release (ER) tablet Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

| Member Information (required) | | | Provider Information (required) | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NPI#: | Specialty: | |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |

## Medication Information (required)

| Medication Name: | Strength: | Dosage Form: |
|---|---|---|
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis below:**

❑ Generalized anxiety disorder [**Effexor XR** only]
❑ Major depressive disorder
❑ Panic disorder [**Effexor XR** only]
❑ Social anxiety disorder
❑ Other diagnosis: ____________________________ ICD-10 Code(s): __________________________________

**Select the medications the patient has a failure, contraindication, or intolerance to:**

❑ Aplenzin
❑ Bupropion
❑ Bupropion ER
❑ Bupropion sustained-release (SR)
❑ Bupropion XL
❑ Citalopram
❑ Desvenlafaxine ER
❑ Desvenlafaxine ER (Pristiq)
❑ Duloxetine 20mg, 30mg, 60mg
❑ Duloxetine 40mg
❑ Escitalopram
❑ Fetzima
❑ Fetzima Titration Pack
❑ Fluoxetine
❑ Fluoxetine delayed-release (DR)
❑ Forfivo XL
❑ Khedezla
❑ Mirtazapine
❑ Mirtazapine orally disintegrating tablet (ODT)
❑ Paroxetine
❑ Paroxetine ER
❑ Paxil
❑ Remeron
❑ Remeron Soltab
❑ Sertraline
❑ Trintellix
❑ Venlafaxine ER capsule
❑ Venlafaxine ER tablet 37.5mg, 75mg,150mg
❑ Venlafaxine ER tablet 225mg
❑ Venlafaxine immediate-release (IR) tablet
❑ Viibryd
❑ Viibryd Starter Pack
❑ Other generic antidepressant (e.g., amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, maprotiline, nefazodone, nortriptyline, phenelzine, protriptyline, trazodone, tranylcypromine, trimipramine)

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

___________________________________________________________________________________________

___________________________________________________________________________________________

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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