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

Khedezla™ & desvenlafaxine extended-release (ER) Prior Authorization Request Form

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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:
❑ Major depressive disorder (MDD)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

- ❑ Bupropion
- ❑ Bupropion extended-release (XL)
- ❑ Bupropion sustained-release (SR)
- ❑ Citalopram
- ❑ Desvenlafaxine ER
- ❑ Desvenlafaxine ER (Pristiq)
- ❑ Duloxetine 20mg, 30mg, 60mg
- ❑ Duloxetine 40mg
- ❑ Escitalopram
- ❑ Fetzima
- ❑ Fetzima Titration Pack
- ❑ Fluoxetine
- ❑ Fluoxetine delayed-release (DR)
- ❑ Forfivo XL
- ❑ Mirtazapine
- ❑ Mirtazapine orally disintegrating tablet (ODT)
- ❑ Paroxetine
- ❑ Paroxetine ER
- ❑ Paxil
- ❑ Remeron
- ❑ Remeron Soltab
- ❑ Sertraline
- ❑ Trintellix
- ❑ Venlafaxine ER capsule
- ❑ Venlafaxine ER tablet
- ❑ Venlafaxine IR tablet
- ❑ Viibryd
- ❑ Viibryd Starter Pack

Does the patient have a history of failure, contraindication, or intolerance to generic Selective Serotonin Reuptake Inhibitors (SSRIs), generic Serotonin Norepinephrine Reuptake Inhibitors (SNRIs), OR other generic antidepressants not listed above? ❑ **Yes** ❑ **No**
If Yes, please specify all: _____

Quantity limit requests:
What is the quantity requested per DAY? _____
What is the reason for exceeding the plan limitations?
❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: _____
❑ Other: _____

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.