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

Lexapro® 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:

- ❑ Generalized anxiety disorder (GAD)
- ❑ Major depressive disorder (MDD)
- ❑ Mixed anxiety and depressive disorder
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

- ❑ Aplenzin
- ❑ Bupropion
- ❑ Bupropion extended-release (ER)
- ❑ Bupropion sustained-release (SR)
- ❑ Bupropion XL
- ❑ Buspirone
- ❑ 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
- ❑ Paxil
- ❑ Remeron
- ❑ Remeron Soltab
- ❑ Sertraline
- ❑ Trintellix
- ❑ Venlafaxine ER capsule
- ❑ Venlafaxine ER tablet
- ❑ Venlafaxine immediate-release (IR) tablet
- ❑ Viibryd
- ❑ Viibryd Starter Pack
- ❑ Other generic antidepressant (e.g., amitriptyline, amoxapine, clomipramine, desipramine, doxepin, imipramine, maprotiline, nefazodone, nortriptyline, paroxetine ER, phenelzine, protriptyline, tranylcypromine, trazodone, 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.