



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 <small>(required)</small>	Provider Information <small>(required)</small>
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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 <small>(required)</small>
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Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information <small>(required)</small>
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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:

- | | |
|---|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Aplenzin <input type="checkbox"/> Bupropion <input type="checkbox"/> Bupropion extended-release (ER) <input type="checkbox"/> Bupropion sustained-release (SR) <input type="checkbox"/> Bupropion XL <input type="checkbox"/> Buspirone <input type="checkbox"/> Citalopram <input type="checkbox"/> Desvenlafaxine ER <input type="checkbox"/> Desvenlafaxine ER (Pristiq) <input type="checkbox"/> Duloxetine 20mg, 30mg, 60mg <input type="checkbox"/> Duloxetine 40mg <input type="checkbox"/> Escitalopram <input type="checkbox"/> Fetzima <input type="checkbox"/> Fetzima Titration Pack <input type="checkbox"/> Fluoxetine <input type="checkbox"/> Fluoxetine delayed-release (DR) <input type="checkbox"/> Forfivo XL <input type="checkbox"/> Khedezla | <ul style="list-style-type: none"> <input type="checkbox"/> Mirtazapine <input type="checkbox"/> Mirtazapine orally disintegrating tablet (ODT) <input type="checkbox"/> Paroxetine <input type="checkbox"/> Paxil <input type="checkbox"/> Remeron <input type="checkbox"/> Remeron Soltab <input type="checkbox"/> Sertraline <input type="checkbox"/> Trintellix <input type="checkbox"/> Venlafaxine ER capsule <input type="checkbox"/> Venlafaxine ER tablet <input type="checkbox"/> Venlafaxine immediate-release (IR) tablet <input type="checkbox"/> Viibryd <input type="checkbox"/> Viibryd Starter Pack <input type="checkbox"/> 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.

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