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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Tofranil® (imipramine hydrochloride [HCl]) & imipramine pamoate Prior Authorization Request Form (Page 1 of 2)

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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:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Continuation of therapy: Is this request for a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is it within the past 120 days? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Select the diagnosis below: <input type="checkbox"/> Bulimia nervosa, binge eating, or eating disorder <input type="checkbox"/> Depression <input type="checkbox"/> Diabetic neuropathy <input type="checkbox"/> Pain <input type="checkbox"/> Panic disorder <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.					
Risk acknowledgment: Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the provider wish to proceed with the originally prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.					
Bulimia nervosa, binge eating, or eating disorder: Select the medications the patient has a failure, contraindication, or intolerance to: <input type="checkbox"/> Fluoxetine <input type="checkbox"/> Fluvoxamine					

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Tofranil-ImipramineHCl-ImipraminePamoate_CMS_2019Feb-W



Tofranil® (imipramine hydrochloride [HCl]) & imipramine pamoate Prior Authorization Request Form (Page 2 of 2)

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Depression:

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

- | | |
|---|---|
| <input type="checkbox"/> Amitriptyline | <input type="checkbox"/> Forfivo XL |
| <input type="checkbox"/> Amoxapine | <input type="checkbox"/> Imipramine HCl |
| <input type="checkbox"/> Aplenzin | <input type="checkbox"/> Imipramine pamoate |
| <input type="checkbox"/> Bupropion | <input type="checkbox"/> Khedezla |
| <input type="checkbox"/> Bupropion extended-release (ER) | <input type="checkbox"/> Mirtazapine |
| <input type="checkbox"/> Bupropion sustained-release (SR) | <input type="checkbox"/> Mirtazapine orally disintegrating tablet (ODT) |
| <input type="checkbox"/> Bupropion XL | <input type="checkbox"/> Nortriptyline |
| <input type="checkbox"/> Citalopram | <input type="checkbox"/> Paroxetine |
| <input type="checkbox"/> Desipramine | <input type="checkbox"/> Paroxetine ER |
| <input type="checkbox"/> Desvenlafaxine ER | <input type="checkbox"/> Paxil |
| <input type="checkbox"/> Desvenlafaxine ER (Pristiq) | <input type="checkbox"/> Protriptyline |
| <input type="checkbox"/> Doxepin | <input type="checkbox"/> Sertraline |
| <input type="checkbox"/> Duloxetine 20mg, 30mg, 60mg | <input type="checkbox"/> Trimipramine |
| <input type="checkbox"/> Duloxetine 40mg | <input type="checkbox"/> Trintellix |
| <input type="checkbox"/> Escitalopram | <input type="checkbox"/> Venlafaxine ER capsule |
| <input type="checkbox"/> Fetzima | <input type="checkbox"/> Venlafaxine ER tablet |
| <input type="checkbox"/> Fetzima Titration Pack | <input type="checkbox"/> Venlafaxine immediate-release (IR) tablet |
| <input type="checkbox"/> Fluoxetine | <input type="checkbox"/> Viibryd |
| <input type="checkbox"/> Fluoxetine delayed-release (DR) | <input type="checkbox"/> Viibryd Starter Pack |

Diabetic Neuropathy:

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

- | | |
|---|--|
| <input type="checkbox"/> Lyrica (pregabalin) | <input type="checkbox"/> Venlafaxine ER tablet |
| <input type="checkbox"/> Venlafaxine ER capsule | <input type="checkbox"/> Venlafaxine IR tablet |

Pain:

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

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Duloxetine 20mg, 30mg, 60mg | <input type="checkbox"/> Ketoprofen |
| <input type="checkbox"/> Duloxetine 40mg | <input type="checkbox"/> Sulindac |
| <input type="checkbox"/> Etodolac | |

Panic Disorder:

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

- | | |
|---|--|
| <input type="checkbox"/> Fluoxetine | <input type="checkbox"/> Venlafaxine ER tablet |
| <input type="checkbox"/> Sertraline | <input type="checkbox"/> Venlafaxine IR tablet |
| <input type="checkbox"/> Venlafaxine ER capsule | |

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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