



**ANTIDEPRESSANTS**

**Provider Help Desk**  
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS

**Vortioxetine Trial:** Dose \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure Reason \_\_\_\_\_

**Antidepressant plus adjunct trials:**

**Antidepressant Trial:** Drug Name & Dose \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure Reason \_\_\_\_\_

**Adjunct Trial:** Drug Name & Dose \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure Reason \_\_\_\_\_

**Requests for Auvelity:**

**Extended-Release Bupropion Trial:** Dose \_\_\_\_\_ Trial Dates: \_\_\_\_\_

Failure Reason \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must match prescriber listed above.)	Date of submission
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**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.