

Prozac Weekly[®] (fluoxetine)
 Prior Authorization Form



Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI #:

If Applicable: Pharmacy Name: _____
 Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP
2

Clinical Consideration	<input type="checkbox"/> Medicaid member stabilized on the daily formulation of fluoxetine (Prozac) for at least two months with adequate response.
	<input type="checkbox"/> Medicaid member must have been non-compliant with daily formulation. PA FOR MEDICAID MEMBERS ONLY. ALL OTHER LINES OF BUSINESS WILL BE DENIED.
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):
	Please attach a copy of the prescription or provide ALL of the information below: Prozac Weekly [®] (fluoxetine) Strength _____ Sig _____ Qty _____ Refills _____
	<i>*Please attach all relevant medical records and test results*</i> We will not process incomplete forms. If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.

STEP
3

**I certify that the above is correct and accurate to the best of my knowledge and that the form is complete.
 (please sign and date)**

 Prescriber Signature

 Date

STEP
4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
 970-248-5034**

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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