

Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Medicare Part B Medicare Part D
 This request is: Expedited request Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

Imipramine (generic Tofranil[®] and Tofranil-PM[®])

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
 Provider Address: _____
 Provider NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

Drug information

New Request Continuation Request

Imipramine 10 mg tablet Imipramine pamoate 75 mg capsule **Start date** (or date of next dose): _____
 Imipramine 25 mg tablet Imipramine pamoate 100 mg capsule **Date of last dose** (if applicable): _____
 Imipramine 50 mg tablet Imipramine pamoate 125 mg capsule **Dosing frequency:** _____
 Imipramine pamoate 150 mg capsule

Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

What condition is this drug being requested for?

- | | |
|---|--|
| <input type="checkbox"/> Agoraphobia | <input type="checkbox"/> Nocturnal enuresis |
| <input type="checkbox"/> Binging | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Bulimia nervosa | <input type="checkbox"/> Panic disorder |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Posttraumatic stress disorder |
| <input type="checkbox"/> Diabetic neuropathy | <input type="checkbox"/> Sexual disorder (such as paraphilia) |
| <input type="checkbox"/> Drug dependence | <input type="checkbox"/> Sleep disorder |
| <input type="checkbox"/> Gardner-Diamond syndrome | <input type="checkbox"/> Trichotillomania |
| <input type="checkbox"/> Globus hystericus | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Other – the patient's condition is: _____ |