PriorityHealth

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 25 mg tablet
☐ Imipramine 50 mg tablet
☐ Imipramine pamoate 75 mg capsule
☐ Imipramine pamoate 100 mg capsule
☐ Imipramine pamoate 125 mg capsule
☐ Imipramine pamoate 150 mg capsule

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

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?

☐ Agoraphobia
☐ Binging
☐ Bulimia nervosa
☐ Depression
☐ Diabetic neuropathy
☐ Drug dependence
☐ Gardner-Diamond syndrome
☐ Globus hystericus
☐ Mood swings
☐ Nocturnal enuresis
☐ Pain
☐ Panic disorder
☐ Postraumatic stress disorder
☐ Sexual disorder (such as paraphilia)
☐ Sleep disorder
☐ Trichotillomania
☐ Urinary incontinence
☐ *Other – the patient's condition is:*

_____

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 11/2017
Last reviewed 11/2019