

- | | | | | |
|-----|--|---|--------------------------|----------------------------|
| | trimipramine (Surmontil) (if checked, go to 14) | | <input type="checkbox"/> | |
| 4. | Does the patient require use of MORE than any of the following: A) 180 units/month of amitriptyline 10 mg, B) 120 units/month of amitriptyline 25 mg, C) 90 units/month of amitriptyline 50 mg, D) 60 units/month of amitriptyline 75 mg, E) 30 units/month of amitriptyline 100 mg, 150 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 5. | Does the patient require use of MORE than any of the following: A) 180 units/month of amitriptyline/perphenazine 10 mg/2 mg, B) 120 units/month of amitriptyline/perphenazine 25 mg/2 mg, 25 mg/4 mg, C) 90 units/month of amitriptyline/perphenazine 50 mg/4 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 6. | Does the patient require use of MORE than 120 units/month of amoxapine 25 mg, 50 mg, 100 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 7. | Does the patient require use of MORE than 180 units/month of chlordiazepoxide/amitriptyline 5 mg/12.5 mg or 10 mg/25 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 8. | Does the patient require use of MORE than any of the following: A) 120 units/month of desipramine (Norpramin) 10 mg, 25 mg, 50 mg, B) 90 units/month desipramine (Norpramin) 75 mg, 100 mg, C) 60 units/month of desipramine (Norpramin) 150 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 9. | Does the patient require use of MORE than any of the following: A) 120 units/month of doxepin 10 mg, 25 mg, 50 mg, 75 mg, B) 90 units/month of doxepin 100 mg, C) 60 units/month of doxepin 150 mg, D) 900 mL /month of doxepin 10 mg/mL? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 10. | Does the patient require use of MORE than any of the following: A) 150 units/month of imipramine (Tofranil) 10 mg, 25 mg, B) 120 units/month of imipramine (Tofranil) 50 mg, C) 60 units/month of imipramine (Tofranil) 75 mg, 100 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 11. | Does the patient require use of MORE than 30 units/month of imipramine pamoate 125 mg, 150 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 12. | Does the patient require use of MORE than any of the following: A) 180 units/month of nortriptyline (Pamelor) 10 mg, B) 90 units/month of nortriptyline (Pamelor) 25 mg, 50 mg, C) 60 units/month of nortriptyline (Pamelor) 75 mg, D) 2,250 mL /month of nortriptyline (Pamelor) 10 mg/5mL? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 13. | Does the patient require use of MORE than any of the following: A) 120 units/month of protriptyline 5 mg, B) 180 units/month of protriptyline 10 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |
| 14. | Does the patient require use of MORE than any of the following: A) 120 units/month of trimipramine (Surmontil) 25 mg, 50 mg, B) 60 units/month of trimipramine (Surmontil) 100 mg? | Y | <input type="checkbox"/> | N <input type="checkbox"/> |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.