Prescriber Criteria Form

Emsam 2025 PA Fax 1401-A v1 010125.docx
Emsam (selegiline transdermal system)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Emsam (selegiline transdermal system).

Drug Name:
Emsam (selegiline transdermal system)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of major depressive disorder (MDD)? [If no, then no further questions.]	Yes ◯	No ◯
2	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to TWO of the following: A) serotonin and norepinephrine reuptake inhibitors (SNRIs), B) selective serotonin reuptake inhibitors (SSRIs), C) mirtazapine, D) bupropion? [If yes, then no further questions.]	Yes ◯	No ◯
3	Is the patient unable to swallow oral formulations?	Yes ◯	No ◯

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____