

Prescriber Criteria Form

Paxil Sus 2025 PA Fax 4617-A v1 010125.docx  
 Paxil Suspension (paroxetine hydrochloride)  
 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 Paxil Suspension (paroxetine hydrochloride).

Drug Name:  
 Paxil Suspension (paroxetine hydrochloride)

<b>Patient Name:</b>		
<b>Patient ID:</b>		
<b>Patient DOB:</b>	<b>Patient Phone:</b>	
<b>Prescriber Name:</b>		
<b>Prescriber Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip:</b>
<b>Prescriber Phone:</b>	<b>Prescriber Fax:</b>	
<b>Diagnosis:</b>	<b>ICD Code(s):</b>	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of any of the following: A) major depressive disorder, B) obsessive compulsive disorder, C) panic disorder, D) social anxiety disorder, E) generalized anxiety disorder, F) posttraumatic stress disorder? [If no, then no further questions.]	Yes	No
2	Does the patient have difficulty swallowing solid oral dosage forms (e.g., capsules, tablets)?	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:** \_\_\_\_\_