Prescriber Criteria Form

Drizalma Sprinkle 2026 PA Fax 3399-A v1 010126.docx
Drizalma Sprinkle (duloxetine)
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 Drizalma Sprinkle (duloxetine).

Drug Name:
Drizalma Sprinkle (duloxetine)

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? [If no, then skip to question 3.]	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? [No further questions.]	Yes	No
3	Is the requested drug being prescribed for the treatment of ANY of the following: A) diabetic peripheral neuropathy, B) fibromyalgia, C) chronic musculoskeletal pain? [If yes, then skip to question 6.]	Yes	No
4	Is the requested drug being prescribed for the treatment of generalized anxiety disorder? [If no, then skip to question 8.]	Yes	No
5	Is the patient 7 years of age or older? [If no, then no further questions.]	Yes	No
6	Has the patient tried duloxetine capsules? [If yes, then no further questions.]	Yes	No

7	Is the patient unable to take duloxetine capsules for any reason (e.g., difficulty swallowing capsules, requires nasogastric administration)? [No further questions.]	Yes	No
8	Is the requested drug being prescribed for ANY of the following: A) cancer pain, B) chemotherapy-induced neuropathic pain?	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:**_____