

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**EMSAM**\_(selegiline transdermal)

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Ext. and options \_\_\_\_\_ Fax# \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO (801) 536-0477**

**CRITERIA:**

- ▶ **Physician** documentation from charted progress notes of failure with minimum of three other antidepressants which may include MAOI
- ▶ Previous intolerance to oral trial of MAOI
- ▶ No concurrent antidepressant therapy

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Telephone request from doctor's office or pharmacy

