Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as “Description” defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as “Criteria” defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms “experimental” and “investigational” are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states’ Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. Incomplete forms or forms without the chart notes will be returned.
Criteria:

- **Criteria for initial therapy:** Fluoxetine 60 mg tablet is considered *medically necessary* when *ALL* of the following criteria are met:
  1. Individual has medical record documentation of a confirmed diagnosis of *ONE* of the following:
     - Major Depressive Disorder (MDD)* in an individual 8 years of age or older
     - Obsessive Compulsive Disorder (OCD)* in an individual 7 years of age or older
     - Bulimia Nervosa* in an adult individual
     - Panic Disorder with or without agoraphobia* in an adult individual
  2. Individual has medical record documentation of being unable to adhere with use of 3 tablets or capsules of generic 20 mg Fluoxetine (documentation of non-adherence must be submitted with the request)
  3. Absence of *ALL* of the following contraindications:
     - Simultaneous use with monoamine oxidase inhibitors (MAOI) or within 14 days of discontinuing a MAOI
     - Starting a MAOI within 5 weeks of stopping Fluoxetine
     - Simultaneous use with Pimozide
     - Simultaneous use with Thioridazine or within 5 weeks of stopping Fluoxetine
     - Simultaneous use with Linezolid
     - Simultaneous use with intravenous Methylene Blue
     - Known hypersensitivity to Fluoxetine
  4. Absence of *ALL* of the following exclusions:
     - Simultaneous use with other Fluoxetine containing products
     - Woman who is breast feeding an infant or child

* Fluoxetine 60 mg tablet is FDA-approved in the pediatric population only for MDD and OCD. The safety and effectiveness in pediatric patients < 8 years of age in MDD and < 7 years of age in OCD have not been established.

- **Continuation of coverage (renewal request):** Fluoxetine 60 mg tablet is considered *medically necessary* with documentation of *ALL* of the following:
  1. The individual has benefited from therapy but remains at high risk
  2. The condition has not progressed or worsened while on therapy
  3. Individual has not developed any contraindications or other exclusions to its continued use
Fluoxetine 60 mg tablet
Fluoxetine 90 mg oral delayed release (once weekly) capsule (cont.)

- **Criteria for initial therapy:** Fluoxetine 90 mg delayed release (once weekly) capsule is considered *medically necessary* when **ALL** of the following criteria are met:
  1. Individual has medical record documentation of a confirmed diagnosis of Major Depressive Disorder (MDD) † in an individual 8 years of age or older
  2. Individual has medical record documentation of being unable to adhere with generic Fluoxetine 20 mg once daily tablet or capsule (documentation of non-adherence must be submitted with the request)
  3. Absence of **ALL** of the following contraindications:
      1. Simultaneous use with monoamine oxidase inhibitors (MAOI) or within 14 days of discontinuing a MAOI
      2. Starting a MAOI within 5 weeks of stopping Fluoxetine
      3. Simultaneous use with Pimozide
      4. Simultaneous use with Thioridazine or within 5 weeks of stopping Fluoxetine
      5. Simultaneous use with Linezolid
         - Simultaneous use with intravenous Methylene Blue
      6. Known hypersensitivity to Fluoxetine
  4. Absence of **ALL** of the following exclusions:
      1. Simultaneous use with other Fluoxetine containing products
      2. Woman who is breast feeding an infant or child

† Fluoxetine 90 mg capsule is FDA-approved in the pediatric population only for MDD

- **Continuation of coverage (renewal request):** Fluoxetine 90 mg delayed release (once weekly) capsule is considered *medically necessary* with documentation of **ALL** of the following:
  1. The individual has benefited from therapy but remains at high risk
  2. The condition has not progressed or worsened while on therapy
  3. Individual has not developed any contraindications or other exclusions to its continued use

- Fluoxetine 60 mg tablet and 90 mg delayed release (once weekly) capsule for all other indications not previously listed is considered *experimental or investigational* based upon:
  1. Lack of final approval from the Food and Drug Administration, and
  2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
  3. Insufficient evidence to support improvement of the net health outcome, and
  4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
  5. Insufficient evidence to support improvement outside the investigational setting.
FLUOXETINE 60 MG oral tablet
FLUOXETINE 90 MG oral delayed release (once weekly) capsule
(cont.)

Description:

Fluoxetine 60 mg tablet is indicated for the treatment of Major Depressive Disorder (MDD) in individuals 8 years of age or older, for the treatment of Obsessive Compulsive Disorder (OCD) in individuals 7 years of age or older, for the treatment of moderate to severe Bulimia Nervosa in adults, and for the treatment of Panic Disorder, with or without agoraphobia in adults. Fluoxetine 90 mg delayed release once weekly capsule is indicated for the treatment of MDD in individuals 8 years of age or older and is administered once a week. Fluoxetine once weekly capsules contain enteric-coated pellets of fluoxetine hydrochloride equivalent to 90 mg of fluoxetine.

Although the exact mechanism of fluoxetine is unknown, it is presumed to be linked to its inhibition of central nervous system neuronal uptake of serotonin. Fluoxetine hydrochloride is a selective serotonin reuptake inhibitor for oral administration.

Resources:


Fax completed prior authorization request form to 602-864-3126 or email to pharmaceprescert@azblue.com. Call 866-325-1794 to check the status of a request. All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned.** Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

# Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

**REQUIRED:** Office notes, labs, and medical testing relevant to the request that show medical justification are required.

## Member Information

<table>
<thead>
<tr>
<th>Member Name (first &amp; last):</th>
<th>Date of Birth:</th>
<th>Gender:</th>
<th>BCBSAZ ID#:</th>
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</thead>
<tbody>
<tr>
<td>Address:</td>
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<td>City:</td>
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<td>State:</td>
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<td>Zip Code:</td>
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## Prescribing Provider Information

<table>
<thead>
<tr>
<th>Provider Name (first &amp; last):</th>
<th>Specialty:</th>
<th>NPI#:</th>
<th>DEA#:</th>
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<tbody>
<tr>
<td>Office Address:</td>
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<td>City:</td>
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<td>Zip Code:</td>
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## Dispensing Pharmacy Information

<table>
<thead>
<tr>
<th>Pharmacy Name:</th>
<th>Pharmacy Phone:</th>
<th>Pharmacy Fax:</th>
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## Requested Medication Information

<table>
<thead>
<tr>
<th>Medication Name:</th>
<th>Strength:</th>
<th>Dosage Form:</th>
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<tbody>
<tr>
<td>Directions for Use:</td>
<td>Quantity:</td>
<td>Refills:</td>
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<td></td>
<td></td>
<td>Duration of Therapy/Use:</td>
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</table>

- [ ] Check if requesting **brand** only
- [ ] Check if requesting **generic**
- [ ] Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

## Turn-Around Time For Review

- [ ] Standard
- [ ] Urgent. Sign here: _______________________________
- [ ] Exigent (requires prescriber to include a written statement)

## Clinical Information

1. **What is the diagnosis? Please specify below.**
   - ICD-10 Code: __________________________  Diagnosis Description: __________________________________

2. [ ] Yes  [ ] No  Was this medication started on a recent hospital discharge or emergency room visit?

3. [ ] Yes  [ ] No  There is absence of ALL contraindications.

4. **What medication(s) has the individual tried and failed for this diagnosis? Please specify below.**
   Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

<table>
<thead>
<tr>
<th>Medication Name, Strength, Frequency</th>
<th>Dates started and stopped or Approximate Duration</th>
<th>Describe response, reason for failure, or allergy</th>
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5. **Are there any supporting labs or test results? Please specify below.**

<table>
<thead>
<tr>
<th>Date</th>
<th>Test</th>
<th>Value</th>
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Blue Cross Blue Shield of Arizona, Mail Stop A115, P.O. Box 13466, Phoenix, AZ 85002-3466
6. **Is there any additional information the prescribing provider feels is important to this review? Please specify below.**

For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

**Signature affirms that information given on this form is true and accurate and reflects office notes**

Prescribing Provider’s Signature: ____________________________  Date: ________________

**Please note:** Some medications may require completion of a drug-specific request form.

**Incomplete forms or forms without the chart notes will be returned.**

Office notes, labs, and medical testing relevant to the request that show medical justification are required.