



**Alprazolam,  
Alprazolam Intensol,  
Alprazolam ER/XR**

**Express Scripts  
Prior Authorization  
Phone 1-844-424-8886  
Fax 1-877-251-5896**

To start your Part D Coverage Determination request, you (or your representative or your doctor or other prescriber) should contact Express Scripts, Inc (ESI):

- You may Call ESI at 1-844-424-8886, 24 hours a day, 7 days a week, TTY users: 1-800-716-3231
- You may Fax your request to: 1-877-251-5896 (Attention: Medicare Reviews)
- You may also send your request via email to: [medicarepartdparequests@express-scripts.com](mailto:medicarepartdparequests@express-scripts.com)

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:
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**SECTION A**

Please answer the following questions

1. What is the member's diagnosis or indication?

- Anxiety → **please answer question 2**
- Panic disorder → **please answer question 3**
- All other diagnoses (*document diagnosis*):

2.  Yes     No    Has the member used at least one of the following: buspirone, paroxetine, or venlafaxine in the treatment of the member's disease/medical condition prior to the initiation of alprazolam (or are any of these medications likely to cause an allergy/adverse reaction or other harm to the member)?

*If yes, please document 1) medications used (2) contraindications or adverse outcome (3) anticipated significant adverse clinical outcome:*

3.  Yes     No    Has the member used at least one SSRI or one SNRI (e.g., venlafaxine, venlafaxine ER caps, fluoxetine, paroxetine, paroxetine ER, or sertraline) in the treatment of the member's disease/medical condition prior to the initiation of alprazolam (or are any of these medications likely to cause an allergy/adverse reaction or other harm to the member)?

If yes, please document 1) medications used (2) contraindications or adverse outcome (3) anticipated significant adverse clinical outcome:

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**Please document the symptoms and/or any other information important to this review:**

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**SECTION B** Physician Signature

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PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1-877-251-5896**

Our response time for prescription drug coverage standard requests is 72 hours. If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can ask for an expedited (fast) decision. If your prescriber indicates that waiting 72 hours could seriously harm your health, we will automatically give you a decision within 24 hours. If you do not obtain your prescriber's support for an expedited request, we will decide if your case requires a fast decision. You cannot request an expedited coverage determination if you are asking us to pay you back for a drug you already received. View our formulary and Prior Authorization criteria online at <http://www.villagehealthca.com>