Prior Authorization Approval Criteria

Prozac Weekly (Fluoxetine)

Generic Name: Fluoxetine
Brand Name: Prozac Weekly
Medication Class: antidepressant
FDA Approved Uses: Depression, Obsessive compulsive disorder, bulimia nervosa, premenstrual dysphoric disorder
Usual Doses: One capsule once weekly.
Duration of Therapy: Indefinite

Preferred products

- Fluoxetine (generic Prozac once daily)
- Celexa
- Citalopram
- Zoloft
- Sertraline
- Paxil
- Paroxetine
- Effexor
- Venlafaxine
- Wellbutrin SR and XL
- Buproprion SR and Budeprion XL
- Wellbutrin
- Buproprion
- Nefazodone
- Prozac

Criteria for Use: (bullet points below are all inclusive unless otherwise noted)

- Clinically diagnosed depression, OCD, or bulimia nervosa, premenstrual dysphoric disorder.
- Failed / Intolerant to generic fluoxetine.
- Failed / intolerant to at least 3 preferred products.
- Unable to take medication daily (for reasons other than non-compliance).

Criteria for continuation of therapy:

- Patient is tolerating and responding to medication and there continues to be a medical need for the medication.

Contraindications:

- Hypersensitivity to fluoxetine.
- Concomitant use of MAOI’s and Thioridazine.

Not approved if:

- Patient has any contraindications to the use of fluoxetine.
- Patient does not meet the above stated criteria.

The criteria listed above applies to Fallon Health Plan and its subsidiaries.
Authorization approval duration: indefinite

P&T Approval: ____________________________ Date: ______________