Health Partners
A part of Jefferson Health Plans

HEALTH PARTNERS PLANS
2024 PRIOR AUTHORIZATION REQUEST FORM

Antidepressants - Other

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Patient Name:	Prescriber Name:	
HPP HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Patient Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the request for renewal of prior authorization? If yes, go to 2. If no, go to 5.

☐ Yes ☐ No

Q2. Is the request for Spravato (esketamine)? If yes, go to 3. If no, go to 4.

☐ Yes ☐ No

Q3. Is documentation included showing improvement in disease severity since initiating treatment? If yes, go to 17.

☐ Yes ☐ No

Q4. Is the request for a quantity that exceeds the quantity limit and is medically necessary?

☐ Yes ☐ No

Q5. Is this a request for Zulresso (brexanolone) or Zurzuvae (zuranolone)?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q6. Is Zulresso (brexanolone) or Zurzuvae (zuranolone) being prescribed for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q7. Is Zulresso (brexanolone) or Zurzuvae (zuranolone) age-appropriate for the patient according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q8. Is the patient prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q9. Is the patient taking Zulresso (brexanolone) and Zurzuvae (zuranolone) concomitantly?

☐ Yes ☐ No

Q10. For a diagnosis of postpartum depression (PPD), does the patient meet all of the following:

a) Has depression with onset in the third trimester through 4 weeks postpartum,
b) Has moderate to severe PPD based on a validated depression rating scale (e.g., PHQ-9/EPDS, HAMD-17),
c) Is ≤12 months postpartum,
d) Is not actively psychotic, manic, or hypomanic,
e) Is not currently pregnant

☐ Yes ☐ No

Q11. For all other non-preferred Antidepressants, Other, is there a current history (within the past 90 days) of being prescribed the same non-preferred Antidepressant, Other (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)?

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q12. Is the patient prescribed the Antidepressant, Other for the treatment of a diagnosis that is indicated in the FDA-approved package labeling or a medically accepted indication?

☐ Yes ☐ No

Q13. Is the Antidepressant, Other age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q14. Is the patient prescribed a dose and frequency that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q15. Does the patient have a contraindication to the prescribed medication?

☐ Yes ☐ No

Q16. Does the patient meet at least two of the following:

a) Has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Antidepressants, Other approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥6 weeks.

b) Has a history of therapeutic failure of or a contraindication or an intolerance to the Antidepressants, SSRIs approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥6 weeks.

c) Has a history of therapeutic failure of or a contraindication or an intolerance to augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥6 weeks?

☐ Yes ☐ No

Q17. Is this a request for Spravato (esketamine)? If yes, go to 18. If no, go to 22.

☐ Yes ☐ No

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Patient Name:	Prescriber Name:

Q18. Is Spravato (esketamine) prescribed by or in consultation with a psychiatrist?

☐ Yes ☐ No

Q19. Is Spravato (esketamine) being prescribed in conjunction with a therapeutic dose of an oral antidepressant?

☐ Yes ☐ No

Q20. Is Spravato (esketamine) being prescribed at a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q21. Does the patient have severe hepatic impairment (Child-Pugh class C)?

☐ Yes ☐ No

Q22. Does the quantity exceed the quantity limit set by the plan?

☐ Yes ☐ No

Q23. Is it medical necessary for the patient to exceed the quantity limit?

☐ Yes ☐ No

Q24. Additional Information:

_____ _____

Prescriber Signature Date

Updated for 2024